THE
BIRDS & BEES
PROJECT

The Birds & Bees Project's

Educator's Guide to Reproductive Health

Since 1977, The Birds & Bees Project has been providing medically accurate reproductive and sexual heath information to youth and adults in the Twin Cities metro area. Each year, we present our innovative curriculum to over 8,000 students and adults in area high schools, alternative learning centers, correctional facilities, churches, synagogues and adult-education programs. Additionally, we provide educational resources through publications and our website, www.birdsandbees.org, to educators, parents and youth nationwide.

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The Seventh Edition of The Birds & Bees Project's Educator's Guide to Reproductive Health was written and assembled by Nikki Madsen – Director of The Birds & Bees Project, Amanda Danzeisen – The Birds & Bees Project Coordinator, and Julia C. Johnsen, MPP. Additional copies of this guide may be downloaded at www.birdsandbees.org.

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Bringing the Birds & Bees Project into your classroom

Each year in the United States, over 750,000[i] teens become pregnant and find themselves making tough choices with lasting impacts. Additionally, 9 million new cases of sexually transmitted infections (STIs) are reported among the youth in our country every year[ii]. These statistics emphasize the responsibility and challenges we have as educators to prepare our young people to make healthy choices about their sexuality.

To help you meet this challenge, The Birds & Bees Project staff has developed the Educator's Guide to Reproductive Health. We use the information contained in this guide to educate more than 8,000 young people in the Twin Cities metro area each year. Our sessions cover basic information about abstinence, contraceptives, STIs and unintended pregnancy options. The chapters presented here will provide you with the information, activities, and strategies necessary to discuss these topics with youth in grades 6-12 using developmentally appropriate, medically accurate, neutral language. Additionally, the activities we have chosen will allow your students to examine reproductive health topics within the context of their own lives, leading to further exploration and clarification of their values.

i. Henshaw S.K. (2003). U.S. Teenage Pregnancy Statistics with Comparative Statistics for Women Aged 20-24. New York: The Alan Guttmacher Institute.

ii. Guttmacher Institute (2006). Facts on Sexually Transmitted Infections in the United States. Retrieved September 2006 from http://www.guttmacher.org/pubs/fb_sti.html.

When teaching reproductive health, it is important to provide comprehensive information. Therefore, this guide would not be complete without a frank and honest discussion about abortion. While abortion is clearly not the choice for every person, nearly half of all unintended pregnancies end in abortion. We believe that no other resource guide exists that is as extensive and unbiased in its coverage of this controversial topic.

We recognize that teaching reproductive health can be difficult. To support you in providing youth with this information, we have structured the goals and objectives for each chapter and activity based on the National Health Education Standards and the guidelines for sexuality education set forth by the Sexuality Information and Education Council of the United States (SIECUS). Additionally, we have provided you with sample letters to send home to parents, copies of our reproductive health brochures (Appendix A), and a list of additional reproductive health website resources (Appendix B). We have also recently updated our Birds & Bees Project website so you can ask our trained education professionals questions as well as download additional materials and receive periodic reproductive health information updates.

We believe that the information in this guide fills a gap that other resources have not been able to provide; however, we encourage you to complement this guide with comprehensive sexual education (CSE) resources and materials. For additional information on recommended CSE curricula, contact the Minnesota Sexuality Education Resource Review Panel.

We hope that you will find the Educator's Guide to Reproductive Health an effective and easy-to-use resource. If your school or organization is located in the Twin Cities metro area and you would like to invite a Birds & Bees Project educator into your classroom to discuss any of the topics covered in this guide, please contact us at 612-821-9795 or via email at pcr@birdsandbees.org.

Tips for Talking about Reproductive Health

Talking about sexuality, reproductive health, and contraceptive options can be challenging in any setting. Listed below are some tips that may help you to ensure that your classroom or community environment is a supportive and safe place for youth to learn about and discuss these topics.

1. Create a safe environment for sharing:

Set ground rules

It is important that the facilitator establish ground rules for participation prior to introducing the topic of reproductive health. These rules can be developed through a facilitated group process, where the class determines the rules they wish to adhere to, or can be established by the facilitator. Rules should be written down, discussed, agreed upon and posted. Rules should always include a rule about respecting others and their opinions, and a rule about confidentiality. It may be important to refer back to the rules as necessary.

2. Youth learn best when they can ask questions:

Let them lead

Young people have many questions, concerns, and opinions about their sexuality and about reproductive health topics in general. Facilitate discussions by posing thoughtful and open-ended questions to draw out these thoughts. Correct misinformation, challenge stereotypes, myth-bust, and challenge your students to do this as well. The exercises and activities in this manual will aid your students in formulating and expressing their views.

3. Youth learn best when they can practice:

Do the activities and exercises

The activities and exercises in this guide are designed to help young people identify and practice strategies for making good decisions

about their sexual health. This includes understanding their personal risks and responsibilities as well as a course for future action. Create an environment where participation, critical thinking and self-reflection - not the "right" answer - is rewarded. The activities are not intended to be handed in and graded, but exercises could be adapted for that purpose.

4. What is abstinence?

Define terms and concepts

Young people have their own language, and adults have another. Terms and concepts like "abstinence", "sex", and "respect" are not universally understood. Take time to discuss and agree on definitions. Acknowledge and address different perspectives, meanings, and opinions. The activities and exercises in this guide will assist you in facilitating this process.

5. When a square peg doesn't fit in a round hole:

Special circumstances are special

Circumstances will arise that require resources that are beyond the scope of this guide. Populations of young people with special needs or increased risks, new Americans, Gay, Lesbian, Bi-sexual, Transgender and Questioning (GLBTQ) youth, and others may have additional needs for information. Use the resources provided in Appendix B to ensure that these important needs are addressed.

6. Planting a seed

Encourage discussions outside of the classroom

The information about sexuality, reproductive health, and decision-making that young people receive through your efforts will continue to evolve and develop as they mature. Encourage students to talk with their parents and/or other trusted adults and friends about the topics discussed in these lessons.

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Chapter 1: Communication

Many adolescents and adults feel extremely uncomfortable talking about issues related to sex and sexual health. Even though young adults realize that discussions with partners, parents, and health care providers are beneficial to their personal health and emotional well-being, teens report that they still have difficulty feeling comfortable using appropriate terminology and engaging in these conversations.[i] Thus, providing instruction and opportunities to practice effective communication is an essential part of any sexuality education curriculum.

This chapter includes activities that we believe will help increase your students' skill level and confidence when talking about their sexual health. Because good parent-child communication is imperative to healthy outcomes, we strongly suggest that you encourage parents to participate in teaching their children this important information. Resources for parents, teens, and educators specific to communication, as well as all of the topics in our guide, can be found on The Birds & Bees Project website as well as in Appendix B. Last, have fun and enjoy this exceptional opportunity to communicate this important information with your students!

i. Kaiser Family Foundation (2003). National Survey of Adolescents and Young Adults: Sexual Health Knowledge, Attitudes and Experience. Retrieved September 2006 from http://www.kff.org/youthhivstds/upload/National-Survey-of-Adolescents-and-Young-Adults-Sexual-Health-Knowledge-Attitudes-and-Experiences-Summary-of-Findings.pdf.

Before you begin:

1. Prior to beginning the lessons and activities included in this guide, it is recommended that a letter be sent home to parents/guardians. This will allow the parents/guardians to start a conversation with their child or to withdraw the child from the classroom while this information is being presented. Sample letters have been provided to assist you in writing your own letter. Include a copy of The Birds & Bees Project Brochure, "How Do I Talk to my Kids about Sex?" when sending the notification letter home (see Appendix A for both).

2. Define the term "sexual partner." Teens today are engaging in sexual behaviors with people that they do not necessary identify as their boyfriend or girlfriend. "Friends with benefits," "hooked up" or "fooled around" may be some terms you have heard your students use to identify the people with whom they are engaging in sexual behaviors. Throughout the guide we have used the term "sexual partner" to mean any person with whom your students are engaging in any sexual behavior – whether they engage in the behavior once or are in an ongoing relationship with that person.

3. If you are particularly uncomfortable teaching this topic or new to the field, invite some friends over and review the activity with them before you try it out with your students – it's the perfect recipe for a fun and unique dinner party.

Fast Facts:

1. The teens we teach tell us that the majority of information they receive about sexual health comes from their sex education courses at school and from their friends.[ii]

2. Teens who feel closely connected to their parents are more likely to abstain from sex, wait until they are older to begin having sex, have fewer sexual partners, and use contraception more consistently. [iii]

3. Over half of the teens we teach tell us that they would be willing to start a conversation with their parents about the following general reproductive health topics: healthy relationships, unplanned pregnancy options (parenting, adoption and abortion), contraception options, STIs/HIV and Sexual Abuse. Teens are less likely (only 1 in 3) to start a conversation with their parents about sex or "making out." [iv]

Goals:[v]

After completing the lessons and activities in this chapter on communication, participants will:

1. Comprehend how communication skills are related to promoting sexual health and preventing unintended pregnancy.
2. Demonstrate the ability to practice effective interpersonal communication skills to promote sexual health.
3. Demonstrate the ability to use communication skills to advocate for personal, family and community sexual health.

ii. The Birds & Bees Project (2005-2006). "The Birds & Bees Talk" online survey. Completed by students.

iii. Blum, R.W. & Rinehard, P.M. (1998). Reducing the Risk: Connections that make a difference in the lives of youth. Center for Adolescent Health and Development, University of Minnesota, Minneapolis. MN. http://www.teenpregnancy.org/works/pdf/Parental_Influence.pdf

iv. The Birds and Bees Project (2005-2006). "The Birds & Bees Talk" online survey. Completed by students.

v. Adapted from National Standards, QTN Minnesota Benchmarks, and Sample Activities in Health Education: Kindergarten through Grade 10. Quality Teaching Network in Health Education and Physical Education, in cooperation with the Minnesota Department of Education. (2006).

vi. Adapted from the Guidelines for Comprehensive Sexuality Education: Kindergarten – 12th Grade, Third Edition (2004). Sexuality Information adn Education Council of the United States. Available online at: www.siecus.org.

Key Learning Points:[vi]

- Different people have different styles of communicating.
- People who have different styles of communicating may have a difficult time understanding each other.
- Communication about sexuality can enhance relationships, but sometimes people are uncomfortable discussing sexuality in an open manner.
- Good communication is essential to personal relationships.*
- Communication about sexual feelings, desires and boundaries can improve a sexual relationship.*
- Communication is necessary to ensure consent for a sexual relationship and any sexual behavior.*

*Additional key learning points for ages 15 to 18

Communication

Activity 1: Breaking the Language Barrier[vii]

vii. Adapted with the permission of the Unitarian Universalist Association. Our Whole Lives: Sexuality Education for Grades 7-9 by Pamela M. Wilson is available at (800) 215-9076 or www.uua.org/bookstore

Time:

45-55 minutes

Audience:

Ages 12 and above

Materials:

Paper
Markers
Masking tape

Activity:

a. Ask students to brainstorm different ways that we talk about sexuality, or sexual things. What types of language do we use with different people or in different situations?

b. Hang up the paper listing the four languages of sexuality and verbally note that sexuality can be discussed in at least four different "languages."
   i. **Scientific Language:** words such as "fallopian tubes" or "sexual intercourse", designed for accuracy.
   ii. **Childhood Language:** words such as "wee wee" or "number two", designed to hide embarrassment, or to avoid explicit conversation.
   iii. **Street/Slang Language:** words or phrases such as "getting it on "or "boob", designed to be informal and to be used by specific cultural subgroups (such as teens).
   iv. **Common Language:** words or phrases such as "making love" or "having sex", designed to communicate information plainly.

c. Ask participants to form small groups (note: for ages 12-15 we recommend same gender groups) to do some brainstorming.

Explain that the purpose of this exercise is to increase people's ease in talking about sexuality.

d. Give the following instructions:
   - I will say a sexual word, and as soon as it is given, each group is to brainstorm and write down all the synonyms (words meaning the same) for that word, using any or all of the four languages we use to talk about sex.
   - Choose one person in your group to be the recorder, the person who writes the words down on the paper as quickly as you can say them.
   - When I call "time", you are to stop. The goal of this exercise is to generate the longest list.

e. Give each group a few sheets of paper and a marker, and then give the first word - "penis". Call "time" after two to three minutes and ask each recorder to count the synonyms the group has brainstormed. Determine which group has the most words, then ask the recorder (or someone else) to read the list of words for "penis". Ask the other groups to add words that have not yet been mentioned.

f. Continue with some or all of the following words (or others)*:

Penis	**Vaginal Sex**	**Breasts**
Vagina	**Oral sex**	**Menstruation**
Masturbation	**Anal Sex**	**Testicles**

* Note: all of the above words are developmentally appropriate for ages 12 and above. However, for ages 12-15 we have found it more effective to use the word sex (encompassing vaginal, anal and oral) rather than separating it into three distinct categories.

g. Ask the following discussion questions as part of the larger group.

Questions for ages 12-15:

1. When we first started, how did you feel about doing the exercise? What happened to your feelings and comfort level as the exercise progressed?

2. Which words were difficult to say (or hear)? What made it difficult?

3. How did you feel about saying or hearing the words with people of your same gender (in small groups)?

4. What was it like to say or hear particular words in the large groups with members of another gender?

5. What differences did you notice in words for female and males? Do certain types of words have a more negative or positive association?

6. What kinds of words are you most comfortable with/least comfortable with?

NOTE: Words have different meanings for different people. Some feel that street language is totally negative, while others use that language in loving ways in the context of their relationship.

7. What problems might occur if you and your parents had different styles of communication specific to sex? What problems might occur if someone and their sexual partner have different styles?

8. What are the benefits for people who are able to talk about sexuality in an open manner?

9. End the discussion by mutually agreeing on the type of language that is the most respectful to use and agree to use it in the classroom. What language do you feel most comfortable using? With parents? With a health care person? With your friends? With your sexual partner? What language do you think we should use (here)?

Questions for ages 15-18:

1. When we first started, how did you feel about doing the exercise? What happened to your feelings and comfort level as the exercise progressed?

2. Which words were difficult to say (or hear)? What made it difficult?

3. What patterns do you notice within the lists (e.g. negative/positive, female/male, etc.)?

For questions 4-5 have the teens focus only on the lists for Vaginal Sex, Anal Sex and Oral Sex.

4. Let's say you are trying to communicate your feelings, desires and boundaries with your sexual partner. If all the above words listed are synonyms for sex, how would your sexual partner understand what specifically you meant if you said "do you want to have sex?" Could the same problems occur that we listed earlier when we talked about styles of communication? What additional problems might we add to the list? How can you be sure that your sexual partner is consenting to the same sexual experience as you if the words you use are vague or if you are using different communication styles?

5. What are the benefits for people who are able to talk about sexuality in an open manner?

6. End the discussion by mutually agreeing on the type of language that is the most respectful to use and agree to use it in the classroom. What language do you feel most comfortable using? With parents? With a health care person? With your friends? With your sexual partner? What language do you think we should use (here)?

Communication

Activity 2: Practice Makes...for Better Communication

Time:

20 minutes – homework assignment

Audience:

Ages 12 and above

1. Pass out the brochures "How to Talk to My Parent About Sex" (see Appendix A) to the students in the class and go over the tips with your students.

2. Have your students pick a reproductive health topic of their choice (e.g., healthy relationships, parenthood, birth control, etc.).

3. Ask your students to work with a parent, both parents or a trusted adult and explain that both the student and the adult will sit down together and separately brainstorm all the words that come to mind describing the chosen topic for 3 minutes (similar to the Activity 1 that they just participated in during class).

4. Next, have the student and adult compare their lists and discuss why they chose the words they did to describe the topic.

5. Discussion for parents and students in the class:
   a. Describe the similarities or differences in your and your parent's lists.
   b. Did you learn anything about your own values or your parent's values specific to this topic?

c. Did you use different words or “languages” than your parent to convey the same meaning or value?
d. Was it more or less difficult to discuss this topic with your parent than you expected?

Note: Make sure to give your students at least 3 days to complete this task as some students will prefer to do this with a trusted adult rather than their parent. Make time for students to discuss their experiences in class.

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Chapter 2: Pregnancy and STI Prevention

Introduction:

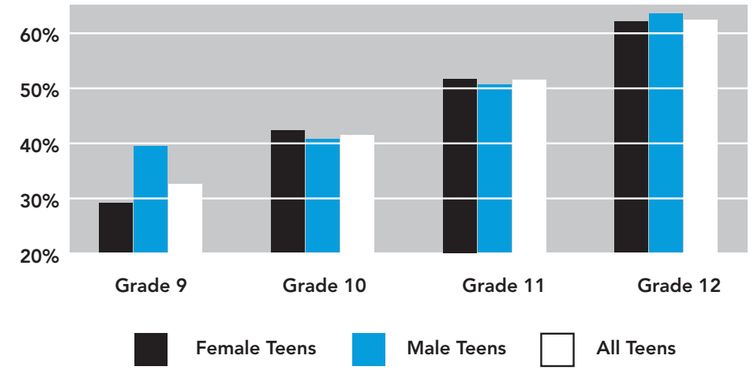
Although abstinence is the most effective method of preventing pregnancy, research shows that it is not always the choice being made by youth. While the majority of teens under the age of 16 do abstain from sexual intercourse, approximately 18 percent of female and 21 percent of male ninth graders in Minnesota are sexually active. The numbers of sexually active youth increase throughout high school, with 49% of female and 46% of male Minnesota twelfth graders reporting that they are sexually active.[i]

Respecting youth and their decision to be, or not to be, sexually active is very important. One way of showing teens that you respect their right to make their own choices is by presenting them with information that applies to their particular, personal situation. In order to reach every student with information that he or she needs to make healthy, responsible decisions about his or her sexual behavior, educators need to provide their students with a broad spectrum of information. To help you do that, this chapter covers everything from abstinence to emergency contraception.

i. MOAPPP (2006). Minnesota State Adolescent Sexual Health Report. Retrieved Sept. 2006 from http://www.moappp.org/Documents/2006AdoHealthReport.pdf.

Fast Facts:

1) Providing youth with information about delaying initiation of sexual intercourse and improved contraceptive practice contributed equally to declines in pregnancy and STI/HIV rates among high school-aged teens over the past ten years.[ii]
2) Sexuality (and HIV) education DOES NOT encourage earlier participation in sexual activity.[iii]
3) The following table reflects national statistics regarding the percentage of teens that have had sex at least once by grade twelve (2005).[iv]



ii. Santelli, T.S. et al. (2004). Can changes in sexual behaviors amoung high school students explain the decline in teen pregnancy rates in the 1990s? Journal of Adolescent Health, 35: 80-90.

iii. Kirby, D. (2001). Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy. The National Campaign to Prevent Teen Pregnancy.

iv. Center for Disease Control and Prevention (2006). MMWR Surveillence Summaries: Youth Risk Behavior Surveillance - U.S. 2005. 2006: 55 (No. SS-5). Retrieved Sept 2006 from http:///www.cdc.gov/mmwr/preview/mmwrhtml/ss5505al.htm.

Chapter Overview Activity: Plan A, B & C

Time:

20 minutes

Ages:

12 and up

Activity:

This activity is designed to give your students an overview of all the issues you will be discussing in both Chapters Two and Three. Additionally, it provides a simple reference for you and your students to use, helping to put each topic into a larger reproductive health context. The goal of this activity is for teens to recognize that sexual heath involves planning for the future as well as preparing for the unexpected.

1. Begin by discussing with your students when and why you might make a plan (keep in mind that plan is used generically here, not just for a sexual encounter), such as a plan to do something, go somewhere, or take care of something. Ask your students to name something that they did today or yesterday that required a plan (examples: getting up for school on time, choosing what to have for breakfast, deciding when and where to meet with friends).

2. If it is not brought up, discuss plans that specifically deal with health and safety such as: a meeting place if someone gets separated from the group, a work-out plan or a fire escape plan.

3. After talking about when you make a plan, ask your students why someone would make a plan. Make sure to stress health, safety and personal beliefs during this discussion.

4. Transition the conversation into the importance of having a plan for sexual health. Why might it be important to have a plan? Students will say things such as "so you don't 'go farther' sexually than you want to", "so you don't end up with an STI or an unplanned pregnancy", etc.

5. Put up the letters "ABC" vertically on the board and ask what the "A" might stand for in a sexual health plan. Typically, students will yell out abstinence immediately. Tell your students that 99.9% of the population will stop practicing abstinence at some point in their lives, so everyone should have a back-up plan for when they decide to stop practicing abstinence.

6. Then ask what the "B" might stand for when someone chooses to stop practicing abstinence. Students will say birth control and some might even say "Plan B," the brand name for emergency contraception (please bring up Plan B here if your students do not).

7. Tell your students that no form of birth control is 100% effective and then ask what Plan "C" might be if your birth control fails. Typically, students will say parenting, adoption and abortion but may not come up with the word "choice." This is a good time to define the term Pro-Choice as supporting a person's decision to choose parenting, adoption or abortion and Pro-Life (or Anti-Choice) as supporting only parenting or adoption.

A = Abstinence
B = Birth Control, Emergency Contraception
C = Choice: Parenting, Adoption & Abortion

8. Have students watch "Captain Condom" by the Youth Performance Company (4 minutes, see enclosed DVD).

9. Discussion questions specific to video (note: for teens ages 12 to 15 you may want to pose these questions and have them watch the video again before answering):

   a. Did the teens in this video have a plan?
   b. Were they prepared to prevent pregnancy and STIs? Why or why not?
   c. Was there a lack of communication between the teens? What questions did they decide they should talk to one another about before engaging in vaginal sex?
   d. Do you think many teens make a "heat-of-the-moment" or "on-the-spot" decision to have sex rather than discussing the decision and thinking about consequence of the decision beforehand?
   e. What might have happened if Captain Condom did not show up?
   f. What are the benefits of having a plan for your sexual health before putting yourself into a sexual situation?

10. Before you finish the activity reiterate the importance of having a plan for your own sexual health. Explain to the students that you will be going over more specific pieces of the plan that deal with their health, safety and personal beliefs over the next couple weeks to provide them the tools they need to create their own plan for sexual health and well-being.

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Pregnancy & STI Prevention

Lesson 1: Abstinence

Introduction:

Given the risks of pregnancy and sexually transmitted infections (STIs) that accompany early initiation of sexual intercourse, there is a strong rationale for young people to stay sexually abstinent. Unfortunately, many teens interpret any encouragement to be abstinent as an attempt to negate their natural sexual feelings and desires and to prohibit all sexual contact with a partner. To make abstinence a viable option for young people, educators and parents must recognize and affirm teen sexuality and understand that it is developmentally appropriate for adolescents to feel sexual feelings, to desire sexual relationships, and to want to engage in sexual behaviors. For additional resources to learn more about normative sexual development, visit the Advocates for Youth website: http://advocatesforyouth.org/parents/index/htm where you can review Sexual Growth and Development – What Parents Need to Know.

The abstinence lesson that follows is designed to help youth explore and expand their definition of abstinence, as well as challenge them to practice some of the skills necessary to avoid engaging in sexual behaviors before they are ready. After participating in the activity, you and your students can create a classroom definition of abstinence. For purposes of the guide, The Birds & Bees Project defines abstinence as: *not engaging in any sexual activity that may result in becoming pregnant, getting someone pregnant, or spreading or contracting an STI or HIV.* An alternative definition that is commonly used is *abstaining from oral, anal, and vaginal intercourse.* These definitions permit a variety of forms of physical closeness and sexual contact, leaving the door open for teens to practice their sexuality in safe and healthy ways.

Before you Begin:

1. It is important to use inclusive language when discussing abstinence. Many abstinence programs use the "abstinence until marriage" messaging or define sex as penile-vaginal. These definitions exclude GLBTQ youth and reinforce stereotypes about gender and sexual orientation. We highly recommend language and definitions that apply to all youth, regardless of their sexual orientation, such as "significant other" and "partner". Using "abstinence" rather than "abstinence until marriage," defining sex as oral, anal, and vaginal rather than just vaginal, and redirecting stereotypes (such as boys are always interested in sex) will help to create a respectful and inclusive classroom environment.

2. When teaching abstinence, keep in mind that abstinence is a viable option for all young people – those who have not yet had sexual intercourse as well as those who have.

3. Keep in mind that not all people who have had sex chose to have sex. See Appendix B for resources specific to sexual violence.

Fast Facts for Lesson 1:

1. Abstinence (see Birds & Bees Project definition) is the only 100 percent effective method for avoiding unplanned pregnancy and sexually transmitted infections, including HIV.
2. Even adults are confused when it comes to defining abstinence. In a study of college freshmen and sophomores, 37 percent described oral sex and 24 percent described anal sex as abstinent behaviors.[i]

i. Remez, L. (2000). Oral sex among adolescents: is it sex or is it abstinence? Family Planning Perspectives, 32, 298-304.

Goals:[ii]

After completing the lessons and activities in this chapter, participants will:

1. Comprehend what abstinence is, and how it may be used successfully when related to promoting sexual health and preventing unintended pregnancy.

2. Be able to define abstinence and demonstrate the ability to use interpersonal communication skills to enhance health.

3. Demonstrate the ability to use goal-setting and decision-making skills to promote the use of abstinence to prevent pregnancy and STIs/HIV.

ii. Adapted from National Standards, QTN Minnesota Benchmarks, and Sample Activities in Health Education: Kindergarten through Grade 10. Quality Teaching Network in Health Education and Physical Education, in cooperation with the Minnesota Department of Education. (2006).

Key Learning Points:[iii]

1. People may have different ideas about what constitutes abstinence, from no sexual contact of any kind to abstaining only from sexual intercourse, and all points in between.

2. Sexual abstinence is the best method to prevent pregnancy and STIs/HIV.

3. Teenagers who have already had sexual intercourse can choose to be abstinent in that relationship and/or future relationships.

4. Sexual intercourse is not a way to achieve adulthood.*

* Additional key learning points for ages 15 to 18

iii. Adapted from the Guidelines for Comprehensive Sexuality Education: Kindergarten-12th Grade, Third Edition. (2004). Sexuality Information and Education Council of the United States. Available online at: www.SIECUS.org

Activity 1: Defining and Redefining Abstinence[iv]

iv. Adapted with the permission of the Unitarian Universalist Association. Our Whole Lives: Sexuality Education for Grades 7-9 by Pamela M. Wilson is available at (800) 215-9076 or www.uua.org/bookstore.

Time:

45 minutes

Ages:

12-15

Materials:

Paper, Markers, Tape

Before you begin:

Photocopy the handout on the next page or have students copy the following information from the chalkboard or flip chart when they reach Step 4 of this lesson.

Abstinent... Yes? No? Maybe?

Decide if you think a person is abstinent if she or he does the behaviors below.

For each item, check Yes, No or Maybe

	Yes	No	Maybe
1. Cuddling with someone without clothes on			
2. Giving or receiving a body massage			
3. Giving oral sex			
4. Receiving oral sex			
5. Having anal intercourse			
6. Having vaginal intercourse			
7. Holding hands			
8. Kissing			
9. Kissing with open mouths (french kissing)			
10. Rubbing bodies together with clothes on			
11. Rubbing bodies together without clothes on			
12. Masturbating when alone			
13. Masturbating with a partner			
14. Touching a girl's breasts			
15. Touching a partner's buttocks			
16. Touching a partner's genitals			

1. Write the word "abstinence" on the board. Ask participants to brainstorm words that describe what "abstinence" means. List all student responses.

2. Once a list is constructed, ask students the following:
   a. Do the words seem mostly positive or mostly negative?
   b. Does this view of abstinence sound good? Is it a good option for young people?

3. Distribute the Worksheet: "Abstinent…Yes? No? Maybe?" Tell the students not to put their names on the worksheet and complete it privately. Allow about 5 minutes to complete.

4. Have the students hand in their worksheets and ask them to break into 4 small groups. While they are getting into small groups tally their responses and post them on the scoreboard that you previously prepared.

5. Briefly discuss the results as a large group specifically focusing on:
   a. Which of these were the easiest to make decisions about? The hardest?
   b. Why might you or others have voted "maybe" and not been able to clearly decide if the behavior was yes or no?

6. Give each one of the four questions below to each small group to discuss for 15 minutes.
   a. How do you think teens, in general, feel about abstinence as an option? What could happen if two people in a relationship have different definitions of what abstinence means to them?
   b. How would you define virginity? How is virginity different from abstinence? Can you practice abstinence in a relationship if you are not a virgin?
   c. Which of the behaviors on the worksheet could be most risky to a person's health? Does a behavior's risk impact whether or not we should define it as abstinent? Do you think sexual abstinence is the best method to prevent pregnancy and STIs/HIV?
   d. List the advantages of a relationship that includes forms of sexual expression but does not include vaginal, oral or anal intercourse.

7. Have the students report back to the larger group about what they discussed in their small groups.

8. In closing, remind students of the importance of defining "abstinence" for themselves so that they understand their decisions, and can make their boundaries clear to a partner. Write the following sentence on the board and ask participants to complete it privately.

"For me abstinence means it's ok to _____ and it's not ok to_____."

9. Post a definition of abstinence (see suggested definitions in the introduction to abstinence) in your classroom, so it is clear to your students what you mean when you use the word and what you believe they mean when they use the word.

Activity 2: Where does Abstinence End and Sex Begin?[v]

Audience:

15 and up

Time:

45 minutes

Materials:

Paper and markers

Procedures:

- Place students in groups of four or five. Make sure, when possible, to have mixed genders.

- Ask students, "What is sex?" Follow up with, "What is abstinence?"

- Explain to them that we use these terms constantly but what do they really mean? Where does sex begin and abstinence end? For many people engaging in sexual behaviors follows a continuum. For example, it might start with holding hands and end wherever you think it might end. Their task is to create the continuum of sexual behaviors from beginning to end. The placement of where each activity fits on the continuum will vary between groups. Give the groups about 15 minutes to complete their continuum. Make sure to monitor the group discussion. They should use their paper to list or draw the chronology of activities. Remind them to be specific and avoid using slang.

v. Adapted with permission from ©2005 The Haworth Press, Inc. Binghamton, New York, American Journal of Sexuality Education, "Defining Sex and Abstinence: Dialogue Is the Key", Volume 1, Number 1, 159-165. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com>

- At the conclusion of the allotted time, have the students post their charts at the front of the room. Ask the students: Which of the behaviors was the easiest to decide about? The hardest? Discuss the differences and similarities between the answers each group gave.

- Pick one of the group's charts for the class to focus on. Ask the class where on this continuum does sex begin and abstinence end? It may be very surprising where the answers fall. Follow the discussion and ask for rationales. Do not expect agreement by all. It should be noted that everyone is different and not everyone will agree on these things. Some people would not engage in some of the behaviors listed. Why do we have different views about what should be on the charts? Why is it important that we have this conversation?

- Now, ask them as a class to identify where the line should be drawn that would put someone at risk for an STI and why.

- **Discussion Questions (Note: It is important to reiterate what was stated above about everyone being different):**
  - How do people make choices about the activities they engage in? What are factors that influence those decisions?
  - If someone is practicing abstinence, should they have an alternative method of birth control as a "back-up plan" if they decide to be sexually active? Why or why not?
  - How do you think teens, in general, feel about abstinence as an option? What could happen if two people in a relationship have different definitions of what abstinence means to them?
  - How would you define virginity? How is virginity different from abstinence? Can you practice abstinence in a relationship if you are not a virgin?

- Which of the behaviors listed could be most risky to a person's health? Does a behavior's risk impact whether or not we should define it as abstinent? Do you think sexual abstinence is the best method to prevent pregnancy and STIs/HIV?
- List the advantages of a relationship that includes forms of sexual expression but does not include vaginal, oral or anal intercourse.

- It can be helpful to have students journal their reactions to the class discussion. If you are not using journals, a one-page reflection could be used.

THE BIRDS & BEES PROJECT

Pregnancy & STI Prevention

Lesson 2: Contraception

Introduction:

Contraceptives are used to reduce the risk of unintended pregnancy, and, in some cases, to serve as protection against sexually transmitted infections (STIs) and HIV, the virus that causes AIDS. Some methods require a medical exam and prescription, whereas others can be purchased over the counter at nearly any drug or general merchandise retail store. Obtaining the contraceptive methods that require a trip to a clinic or other health care provider can be costly. Most clinics and doctor's offices accept health insurance, or other forms of public medical assistance. For those who do not have health insurance, are low income, or who choose not to use their insurance for purposes of confidentiality, there are some clinics that offer low-cost or free services. Additionally, teens should be aware that as of this 2006 writing, Minnesota law allows them to access all forms of contraception without parental notification and in a confidential manner (see "Minor's Consent" section of Appendix B for more information on this Minnesota law).

Obtaining contraceptives is one thing, but using them effectively is another. There is some chance of failure with every method of contraception, even when it is used carefully and correctly. When choosing the most appropriate method of contraception, many factors must be considered, including: Am I concerned about preventing pregnancy only, or am I also worried about STIs and HIV? How much does this method cost? How effective is this method? Does it have side effects? Do I need to see a doctor or go to a pharmacy to obtain this method? Who is primarily responsible for using this method- me, my partner, or both of us? Is this method something that I am comfortable using (for example, if it involves touching my genitals, am I comfortable with that)?

The information contained in this guide covering the various methods of birth control is meant to be an overview. More detailed information on condoms (lesson 4) and emergency contraception (lesson 5) are found later in this guide. For additional contraception information visit The Birds & Bees Project website (www.birdsandbees.org), or other reputable organizations listed in the "Reproductive and Sexual Health" section of Appendix B.

Before you begin:

1. Review the female reproductive anatomy, including menstruation and pregnancy. It is essential that the students understand the female reproductive system in order to fully understand how many of the contraceptive methods work. Please see Appendix B for suggested anatomy resources. Note that it may seem like students only learn about the female anatomy – ask students why they might spend more time learning about the female reproductive system in the context of contraception (answer: all but one form of contraception, the male condom, works based on the female reproductive system. So in order to understand how contraception works we must first understand female anatomy).

2. Methods of contraception change quite frequently, due to changing availability and new developments in contraceptive technology. For the most up-to-date information please reference The Birds & Bees Project website (www.birdsandbees.org).

3. Use inclusive and gender neutral language, such as "partner" instead of "girlfriend" or "boyfriend" and avoid attributing certain sexual behaviors to specific sexual orientations.

4. You may want to contact a local family planning agency or OB/GYN to get brochures or samples of each contraceptive method for your students to view.

5. Keep in mind that not all of the students are having sex. Talk to your students about why it is important to learn about pregnancy prevention even if they are not sexually active (reference Plan ABC activity on page 158).

Fast Facts:

1. In order to stay healthy, teens need to receive accurate information about contraceptive methods and how to use them effectively. Although 88% of adolescents say that it is important for adolescents to use birth control every time they have sex[i] , only 39% of male and 43% of female Minnesota 9th graders and 60% of male and 69% of female Minnesota 12th graders who have sexual intercourse report that they always use some method of birth control.[ii]

2. Lesbian teens are twice as likely as their heterosexual peers to experience an unintended pregnancy.[iii] "People who are questioning their sexual orientation may experiment in an effort to determine their sexual identity. Sometimes, gay or lesbian people have heterosexual relationships to hide their sexual orientation or for other personal, cultural, or family reasons."[iv]

3. Minnesota Statute 144.343 guarantees minors' right to consent to confidential services including: emergency medical care, pregnancy-related care, care for sexually transmitted diseases, contraceptive care, inpatient mental health services and treatment for alcohol and drug abuse.

i. National Campaign to Prevent Teen Pregnancy. (2000). Risky Business: Teens Tell Us What They Really Think of Contraception and Sex. Washington, DC: Author. Page 1

ii. MOAPPP 2004 MN Student Survey, table 42B http://education.state.mn.us/mde/static/SS%20Statewide%20Tables.pdf

iii. Youth Resource, http://www.youthresource.com/health/index.htm

iv. Ibid

Goals:[v]

1. Students will comprehend the advantages and disadvantages to various methods of contraception.

2. Students will demonstrate how to access information on various contraceptive methods related to health promotion and disease prevention.

3. Students will demonstrate the ability to advocate for personal, family and community reproductive health.

v. Adapted from National Standards, QTN Minnesota Benchmarks, and Sample Activities in Health Education: Kindergarten through Grade 10. Quality Teaching Network in Health Education and Physical Education, in cooperation with the Minnesota Department of Education. (2006).

Key Learning Points:[vi]

- Each birth control method has advantages and disadvantages.

- In addition to preventing pregnancy, some contraceptive methods can also prevent the transmission of STIs and HIV.

- Some contraceptives require a prescription from a health care provider, while others are available without a prescription ("over-the-counter") and can be purchased at a variety of pharmacies, grocery, convenience, or general retail stores.

- In Minnesota, young people can get prescription or over-the-counter contraception without their parents' consent.

- When choosing which method of contraception to use, advantages and disadvantages, as well as effectiveness in preventing pregnancy and STI/HIV transmission, must be considered.*

- Individuals should choose a method that he or she will use correctly and consistently.*

* Additional key learning points for ages 16 to 18.

vi. Adapted from the Guidelines for Comprehensive Sexuality Education: Kindergarden-12th Grade, Third Edition. (2004). Sexuality Information and Education Council of the United States. Available online at: www.SIECUS.org

Overview of Contraception Methods:

The following is a brief overview of all of the contraception methods available. We have included information on pregnancy failure rates, how each methods works, whether or not a prescription is necessary to access the method and if it protects against STIs/HIV. The failure rates for the contraceptive methods listed on the following pages show a range of percentages. The first number is the average failure rate for "perfect use" of that particular method. The term "perfect use" means that the method was used correctly, precisely, and with every act of intercourse. The second number is the average failure rate for "typical use". The term "typical use" means that the method was used correctly the majority of times it was used. For example, if a woman was taking the birth control pill for a year, and she forgot to take it a few times during that year, she would have typical use. According to the failure rates, she would have an 8% chance of becoming pregnant that year. This failure rate does not take into account exposure to STIs or HIV.

Barrier Methods

Barrier methods are among the oldest and most widely-used methods to prevent pregnancy and, in some cases, sexually transmitted infections (only female or male condoms and dental dams prevent STIs). As the name indicates, each method creates a barrier that prevents sperm from reaching the egg or prevents the transmission of infection-causing microorganisms. Some do this primarily by creating a physical barrier: the male and female condom, diaphragm, Lea's Shield and FemCap. Spermicides and the vaginal sponge rely primarily on a chemical barrier agent that kills the sperm. Barrier methods can be used alone, in combinations, or with non-barrier types of contraception – the only exception is that only one male condom or one female condom should be used at a time. When used in combination (for example, a male condom and a sponge) their overall effectiveness against pregnancy increases.

Barrier Method	**Male Condom**
Effectiveness with perfect and typical use	98% - perfect use, 85% - typical use
How it works	They are designed to collect a man's semen during vaginal, oral or anal sex and prevent it from coming in contact with his partner's body. Most are pre-lubricated; however, if they come un-lubricated, a water-based lubricant needs to be applied when engaging in vaginal or anal sex.
Cost	$2-$10 per package
Prescription needed	No
Protects against STIs	Yes, if the condom is latex or polyurethane No, if the condom is sheep skin

Barrier Method	**Female Condom**
Effectiveness with perfect and typical use	95% - perfect use, 79% - typical use
How it works	At each end of the condom there is a flexible ring. At the closed end of the condom, the flexible ring is inserted into the vagina or the anus to hold the condom in place. At the open end of the condom, the ring stays outside the vagina or anus. A water based lubricant should be used.
Cost	$2-$5 per condom
Prescription needed	No
Protects against STIs	Yes

Barrier Method	**Contraceptive Sponge**
Effectiveness with perfect and typical use	91% - perfect use, 84% - typical use
How it works	The sponge is made out of soft polyurethane foam and contains spermicide. After being moistened with water, it is inserted into the vagina. The sponge acts as a barrier to prevent semen from entering the cervix. The sponge must be inserted into the vagina at least 30 minutes before having sex, and needs to remain in the vagina for at least 6 hours after sex.
Cost	$10 for a package of 3 sponges
Prescription needed	No
Protects against STIs	No

Barrier Method	**Diaphragm**
Effectiveness with perfect and typical use	94% - perfect use, 84% - typical use
How it works	The diaphragm is a small rubber dome which is inserted into the vagina and covers the cervix (opening of the uterus). The diaphragm must be completely coated with spermicide prior to insertion, and needs to be left in for at least 6 hours after intercourse. A woman must be fitted for a diaphragm by a physician or nurse. It needs to be refitted after having a baby, a miscarriage, an abortion, or gaining or losing 15 or more pounds.
Cost	$30-$50 for the diaphragm, plus the cost of the initial exam
Prescription needed	Yes
Protects against STIs	No

Barrier Method	**Dental Dam** (for oral sex on the vulva or the anus)
Effectiveness with perfect and typical use	Not Applicable
How it works	The person performing oral sex lays the dental dam (a thin sheet of latex, if purchased, but can also make one out of a condom by unrolling it and cutting it lengthwise) flat over the vulva or anus and holding the edges to keep it in place. The dam functions as a barrier between one partner's mouth and the other partner's vulva or anus and should be used during oral/vaginal (cunnilingus) sex or oral/anal (analingus or rimming) to reduce the spread of STIs and HIV. A new dam should be used if switching partners or switching from oral/anal to oral/vaginal sex.
Cost	$1-$2 each
Prescription needed	No
Protects against STIs	Yes

Barrier Method	**Lea's Shield or FemCap**
Effectiveness with perfect and typical use	94% - perfect use, 84% - typical use
How it works	It prevents pregnancy by blocking the entrance to the cervix. It is made of either silicone or rubber; it fits over the cervix and is held in place by suction. Before insertion it needs to be coated with a spermicide on both sides. It must be left in place for at least 8 hours after intercourse, but for no more than 48 hours.
Cost	$15-$75 plus the cost of the initial exam
Prescription needed	Yes
Protects against STIs	No

Hormonal Methods

When used consistently and correctly, hormonal methods are among the most effective methods of contraception. They are highly popular throughout the world and can be safely used by the vast majority of healthy women. The contraceptive effect of hormonal birth control is reversible and thus when it is discontinued, fertility returns quickly, making it ideal for delaying and spacing pregnancies. Furthermore, many hormonal methods have non-contraceptive health benefits. However, as with any prescription medication, there is always a risk of side effects. Additionally, it should be noted that some medications, such as certain antibiotics, and some types of herbal supplements may decrease the effectiveness of hormonal birth control.

Hormonal Method	**Oral Contraceptive** (the pill)
Effectiveness with perfect and typical use	Over 99% - perfect use, 92% - typical use
How it works	The pill is taken at the same time each day for 28 days (the first 21 days are active pills; the last 7 days are placebos). If one pill is taken more than 6 hours late, or if one pill is forgotten, a back-up method will need to be used for 7 days. The pill contains hormones that are naturally produced by a female's ovaries. These hormones prevent the release of an egg from the ovaries, thicken cervical mucus, and cause changes in the endometrium (inner membrane of the uterus).
Cost	Free to $420 annually, plus the cost of the initial exam
Prescription needed	Yes
Protects against STIs	No

Hormonal Method	**The Patch** (Ortho-Evra)
Effectiveness with perfect and typical use	Over 99% - perfect use, 92% - typical use
How it works	Each patch is worn for 7 days on the upper outer arm, abdomen, butt or the upper torso (front or back, but not on the breasts). At the end of 7 days, a new patch is applied. There are 3 patches used per cycle (3 weeks with a patch, 1 without). The week without the patch is when the woman will have her period. The patch contains hormones that are naturally produced by a female's ovaries. These hormones prevent a release of an egg from the ovaries, thicken cervical mucus, and cause changes in the endometrium.
Cost	$30-$40 per month, plus the cost of the initial exam
Prescription needed	Yes
Protects against STIs	No

Hormonal Method	**NuvaRing**
Effectiveness with perfect and typical use	Over 99% - perfect use, 92% - typical use
How it works	The NuvaRing is a small flexible ring that is inserted into the vagina. The ring is worn for 3 consecutive weeks, at the end of which the woman will remove it and throw it away. During the 4th week the woman is ring-free and will have her period. The ring contains hormones that are naturally produced by a female's ovaries. These hormones prevent a release of an egg from the ovaries, thicken cervical mucus, and cause changes in the endometrium.
Cost	$30-$35 per month, plus the cost of the initial exam
Prescription needed	Yes
Protects against STIs	No

Hormonal Method	**Injectable Hormones** (Depo-Provera)
Effectiveness with perfect and typical use	98%
How it works	An injection of depo-medroxyprogesterone acetate (DMPA) is given in the upper arm or the butt every 12 weeks by a physician to prevent ovulation. DMPA also thickens the cervical mucus. After 12 weeks, if another shot of Depo is not received, the contraceptive effects of the shot will cease.
Cost	$235-$585 annually, including the cost of the exam
Prescription needed	Yes, and the injections are given in a health care professional's clinic.
Protects against STIs	No

Hormonal Method	**Emergency Contraception** (EC or the morning after pill) – see lesson 5 for more information on EC
Effectiveness with perfect and typical use	89-99% (depending on how soon after sex the pill is taken)
How it works	EC consists of hormones, just like those in regular birth control pills. It works by stopping the release of an egg from the ovaries and prevents fertilization. EC is used to prevent pregnancy after sexual intercourse, and is most effective if taken with 72-120 hours (3-5 days) of contraceptive failure, unprotected sexual intercourse, or sexual assault. EC has no effect on an existing pregnancy, and will not cause an abortion. It is NOT meant to be used as a regular form of birth control.
Cost	Free to $35 (some providers require an office visit to obtain EC)
Prescription needed	Yes for teens 17 and under; no, for women 18 and over
Protects against STIs	No

Hormonal Method	**Implanon**
Effectiveness with perfect and typical use	Not yet available
How it works	Implanon was approved by the US FDA in July 2006 and is expected to be available for use in 2007. Implanon is a small, rod-shaped device, about the size of a common matchstick that slowly releases progestin. The device is implanted just under the skin on the inside of a woman's upper arm by a medical professional and is designed to remain in place for up to 3 years. More information can be found on the manufacturer's website: www.organon-usa.com.
Cost	Not available
Prescription needed	Yes
Protects against STIs	No

Permanent Methods

Sterilization is considered a permanent method of birth control that a man or woman chooses – typically in adulthood after they have decided not to have children or have completed childbearing. Although sterilization can sometimes be reversed, the surgery is much more complicated than the original procedure and may not be successful. Thus, when choosing a sterilization method you should not plan on future reversal.

Permanent Method	**Male sterilization** (vasectomy)
Effectiveness with perfect and typical use	99%
How it works	It is a brief operation, which requires only a local anesthetic, where the tube which carries the sperm from the testicles (vas deferens) is cut and sealed shut. The male becomes permanently sterile unless another operation is undergone to re-connect the tube (this is about 60% effective). The operation does not affect the man's sexuality or his ability to have intercourse.
Cost	$350-$1000
Prescription needed	No, a vasectomy is a surgical procedure that must be preformed by a health care professional.
Protects against STIs	No

Permanent Method	**Female sterilization** (tubal ligation)
Effectiveness with perfect and typical use	99%
How it works	It is a brief operation performed in a hospital or clinic, and requires an anesthetic. The fallopian tubes are cut and sealed so that the sperm cannot reach the egg to fertilize it. The female becomes permanently sterile unless another operation is undergone to re-connect the tubes (this is about 30-50% effective). The operation does not affect the woman's sexuality or her ability to have intercourse.
Cost	$350-$1000
Prescription needed	No, a tubal ligation is a surgical procedure that must be preformed by a health care professional.
Protects against STIs	No

Other Methods

Other Method	**Spermicides**
Effectiveness with perfect and typical use	85% - perfect use, 71% - typical use
How it works	Spermicides are chemicals that kill sperm. Spermicides are available in many forms such as foam, jelly, suppository, film, and cream. They should be inserted into the vagina no more than one hour before intercourse (see package for specific insertion instructions for each type of spermicide). Spermicides are most effective when used with another form of contraception, such as a condom.
Cost	$4-$8 per package/bottle
Prescription Needed	No
Protects Against STIs	No

Other Method	**Intrauterine Device (IUD)**
Effectiveness with perfect and typical use	99%
How it works	There are two types of IUDs. One has copper wrapped around it and is hormone free, and prevents sperm from reaching an egg. The other contains no copper, but releases hormones and prevents sperm from fertilizing an egg, as well as prevents a fertilized egg from implanting in the uterus. Depending on the type of IUD, it can last up to 10 years.
Cost	$175-$500, including exam, insertion, follow-up visit and removal
Prescription Needed	An IUD must be inserted in a health care professional's clinic
Protects Against STIs	No

Other Method	**Periodic abstinence** (rhythm method, fertility awareness method)
Effectiveness with perfect and typical use	91% - perfect use, 80% - typical use
How it works	The few days during which a woman is fertile can be calculated with some degree of accuracy by noting daily changes in cervical mucus (cervical mucus method), basal temperature (temperature method), and by calculating days since last period (calendar method). The effectiveness of periodic abstinence depends on discipline and accuracy of record keeping as well as regular menstrual cycles; thus, we do not recommended this method for teens.
Cost	$10-$15 for a thermometer and journal
Prescription Needed	No
Protects Against STIs	No

Other Method	**Withdrawal (pull-out method)**
Effectiveness with perfect and typical use	96% - perfect use, 73% - typical use
How it works	Coitus interruptus, or withdrawal, requires that the male withdraw his penis before ejaculation. The high failure rate of the withdrawal method shows how difficult it can be to judge the exact moment of ejaculation, as well as have the discipline to withdraw the penis before ejaculation. Additionally, there are sperm and possible STIs or HIV present in the liquid that comes out before ejaculation (pre-cum) which can result in pregnancy and STIs and HIV.
Cost	N/A
Prescription Needed	No
Protects Against STIs	No

Activity 1: Contraceptive Commercials[vii]

vii. Adapted from Advocates for Youth, "Contraceptive Commercials." Copyright Advocates for Youth, www.advocatesforyouth.org

Time:

45-50 minutes

Audience:

12-18 years old

Materials:

Picture of each form of birth control and pamphlets or brochures for each method OR internet access

Paper

Markers and other drawing materials

Activity:

Divide your class into small groups of at least 2 students and assign each group a contraception type. If the group is large, some groups can work on duplicate types. If the group is small, be sure to go over methods that were not researched by students.

1. For classrooms without internet access: Provide students with a picture and a description of each method or an easy-to-read brochure that explains how to use the contraceptive methods listed below. Ask them to look over the information and consider the questions on page 54 for about 5 minutes.

OR

1. For classrooms with internet access: Ask students to research the questions on page 54 (specific to the method of contraception they have been assigned) for approximately 10 minutes. Provide students with 5 to 10 medically-accurate websites to choose from when doing this exercise (see Appendix B). Have them visit at least two so they can see if there are differences in the information they receive.

Contraception Types: Male Condom*, Female Condom, Spermicide (foam, film or gel), Birth Control Pills*, Contraceptive Patch (Ortho-Evra)*, Contraceptive Ring (NuvaRing)*, Depo/shot (Depo-Provera)*, Emergency Contraception (morning after pill)*, Contraceptive Sponge, Diaphragm, IUD (ParaGard®, Mirena®), Vasectomy, Tubal Ligation, Abstinence, Withdrawal/pull-out method

Note: if you only have a small group of students, have them focus on the most common methods used by teens which are noted above with an asterisk.*

Questions:

- How does the method prevent pregnancy?
- Can teens get this method without their parent's permission?
- How successful is the method at preventing pregnancy?
- Does the method prevent STI/HIV?
- What makes the method easy for teenagers to use?
- What makes this method hard for teens to use?
- Can teens avoid disadvantages? How?

2. Ask your students to pretend they work for an ad agency that promotes their method of contraception. Design a one-minute television commercial to market their contraceptive method to teens. Be sure to emphasize what makes the method effective and easy to use.

3. Distribute paper, markers, and other drawing materials to each team.

4. Have teens work on their commercials.

5. After 15 to 20 minutes, ask teams to present their commercials to the group. After each presentation, lead the group in a round of applause. Then, correct any misinformation presented. (Remember to go over contraceptive methods not presented on if you have a small class)

6. Conclude the activity using the Discussion Questions (additional questions for ages 15 to 18 are marked with an *):

a. What is the most effective method of birth control? (Answer: abstinence)
b. What is the biggest difference between condoms and other methods of birth control? (Answers: Condoms provide the greatest protection from STIs, including HIV infection. Male condoms are the only method designed specifically for males to use. Teens may also come up with other differences. Write them all down and discuss any inaccuracies.)
c. By combining condoms with any of the other prescription or nonprescription contraceptive methods, couples can increase their protection against both pregnancy and STIs, including HIV. Why do you think that few teenage couples combine condom use with another method of contraception? (Write down all answers.)
d. How old must someone be to purchase over-the-counter birth control, like condoms or the sponge without a parent's permission? How about to get prescription birth control like the pill or ring? (Answer: There is no age requirement.)
e. Are there any places in this community where a teen can get contraception free of charge? (Have students list places to inquire whether condoms and other forms of contraception are available: schools, family planning clinics, STI clinics, at the local health department, etc.)
e. How does a person decide which method of contraception to use? (Answers may include: The person's comfort level in using the method and how easy the method is to use, the method's effectiveness in preventing pregnancy and STIs/HIV, the method's availability and/or cost, whether the method requires touching the genitals and the person's comfort level in doing so, how their partner feels about a particular method, and religious or cultural beliefs).

7. In one page, describe the method(s) of contraception you think would be the most effective for you to use? Have students consider the questions listed in the introduction to this chapter in their papers.*

THE BIRDS & BEES PROJECT

Pregnancy & STI Prevention

Lesson 3: Sexually Transmitted Infections (STI)

Introduction:

Adolescents who are sexually active have a higher risk of contracting Sexually Transmitted Infections than older adults, as a result of various behavioral, biological, and cultural factors. The higher prevalence of STIs among adolescents also reflects multiple barriers to quality STI prevention education and services, including lack of insurance or ability to pay, lack of transportation, discomfort with facilities and services designed for adults, and concerns about confidentiality. Recent estimates suggest that while representing 25% of the ever sexually active population, 15- to 24-year olds acquire nearly 50% of all new STIs.[i] It is highly critical that our youth are receiving accurate and timely information about STIs, including: minor's rights to confidential STI testing, how STIs are prevented and transmitted and what happens if they are left untreated.

Before you begin:

1. Undoubtedly, students will have many questions about STIs, but will not want to ask them - especially in front of a class full of their peers. Before beginning this lesson, place a question box and slips of paper in your classroom. This allows students to ask questions confidentially. Be sure to go through and answer all of the questions, as a class, at some point during the unit.

2. As teachers and educators, we are sometimes asked questions that we just cannot answer. As much as we would like to know everything, the reality is that we do not. In situations like these, it is appropriate to tell the student that you do not know the answer, but you will look up the answer using a trusted resource and get back to the student/class with the correct information.

i. Weinstock, H, Berman, S, Cates, W, Jr. (2004). Sexually Transmitted Diseases among American Youth: Incidence and Prevalence Estimates, 2000. Perspectives on Sexual and Reproductive Health, 36(1):6-10. http://www.cdc.gov/std/stats/adol.htm

3. Some teachers and educators show their students pictures of body parts infected with STIs as an illustration of the symptoms, or in an attempt to scare teens away from having sex. Usually the symptoms depicted in these photographs are from extreme cases of STIs, and are not a common experience of someone with an STI (especially since most people who have an STI are asymptomatic). The Birds & Bees Project does not recommend this practice largely because scare tactics are ineffective and may keep sexually active youth from going in to get tested if their body does not look like what they saw in the pictures, which is most often the case.

Fast Facts:

1. Sexual abstinence is the most effective method of preventing STIs and HIV. For those who are sexually active, consistent and correct use of condoms is the most effective preventative measure.

2. In recent years health professionals have begun using the term STIs rather than STDs because the concept of "disease" implies a clear medical problem and usually some obvious signs or symptoms. But several of the most common STIs have no signs or symptoms in the majority of persons infected. Therefore, the sexually transmitted virus or bacteria can be described as creating "infection," which may or may not result in "disease."[ii]

ii. American Social Health Association (2006). STD/STI Statistics- STD vs. STI. Retrieved September 2006 from http://www.ashastd.org/learn/learn_statistics_vs.cfm

Goals:[iii]

After completing lessons and activities in this chapter, participants will:

1. Be able to identify the nine most common STIs, their symptoms, and effects of being left untreated.

2. Be able to practice health-enhancing behaviors and identify ways to reduce the risks of contracting an STI.

Key Learning Points:[iv]

- Many teenagers will become infected with an STI.
- The symptoms of STIs can be hidden, absent, or unnoticed.
- Untreated STIs can lead to serious and lasting health problems, such as infertility.
- Individuals should discuss STIs and STI prevention with their doctor and sexual partner(s).
- Teens can get confidential testing and treatment for STIs without their parent(s) permission. *
- Young people can help fight STIs by serving as an accurate source of information, by being a responsible role model, and by encouraging others to protect themselves. *

*Additional key learning points for ages 16 to 18.

Overview of Sexually Transmitted Infections (STIs):

The Birds & Bees Project recommends discussing the nine most commonly spread STIs. For more detailed information on STIs, visit the Birds & Bees website (www.birdsandbees.org), or check the websites listed in Appendix B.

iii. Adapted from National Standards, QTN Minnesota Benchmarks, and Sample Activities in Health Education: Kindergarten through Grade 10. Quality Teaching Network in Health Education and Physical Education, in cooperation with the Minnesota Department of Education. (2006).

iv. Adapted from the Guidelines for Sexuality Education: Kindergarten - 12th Grade, Third Edition. (2004). Sexuality Information and Education Council of the United States. Available online at www.SIECUS.org

A. Getting started: When teaching about STIs, it is important to first review the following pieces of information:
   - Explain what an STI is: an infection caused by a parasite, bacteria, or virus that is spread by contact with semen, vaginal fluids, or blood during sexual activity.
   - Explain that the terms STI (Sexually Transmitted Infections) and STD (Sexually Transmitted Diseases) refer to the same thing.
   - In order to help normalize and de-stigmatize STIs, ask the class, "Who gets STIs?" Clarify any misconceptions, and break down stereotypes. Explain that anyone who is sexually active, regardless of: sex, race, age, economic status, sexual orientation, etc. is at risk for contracting an STI. In fact, more than half of all people will have an STI at some point in their lifetime.[v] Explain why teens are especially at risk for getting an STI (see introduction to this chapter).
   - Most people, especially women, do not show symptoms (three out of four females and one out of two males who have an STI do not have symptoms).[vi]
   - Sexually active individuals should get tested after every new sexual partner.
   - When a person tests positive, he or she should notify all past and present sexual partners.
   - Sexual partners should be treated at the same time.
   - For STIs that have a cure, refrain from sexual activity until infection is completely gone. For those that do not, be sure to use a condom or dental dam when engaging in sexual behaviors.
   - You can have more than one STI at a time.
   - Having an STI and treating it does not make a person immune to becoming infected with it again.
   - Having certain STIs can increase a person's risk of HIV infection.
   - If left untreated, some STIs can lead to irreversible damage to internal organs, or infertility.

v. Koutsky L. (1997). Epidemiology of genital human papillomavirus infection. American Journal of Medicine, 102(5A), 3-8. http://www.ashastd.org/learn/learn_statistics.cfm

vi. SIECUS (2003). SIECUS fact sheet: the truth about STDs. Retrieved September 2006 from http://www.siecus.org/pubs/fact/FS_truth_about_stds.pdf

B. Ask students what organisms or germs cause STIs. As they name them ("Parasites," "Bacteria," and "Virus"), write them on the board (see example below). Next, have students help you list the nine most common STIs. As they name the STIs, write them on the board underneath the organism that causes them, until you have all nine on the board. Once again, students may not be able to list all nine, so fill in whichever STIs that they were not able to name.

Parasites	Bacteria	Virus
Pubic Lice (Crabs)	Gonorrhea	HIV
Trichomoniasis	Chlamydia	Hepatitis B
	Syphilis	Herpes
		HPV/Warts

Note: Treatment is available for all STIs, but only Parasitic and Bacterial STIs can be cured. There is currently no cure for any viral STI; however, vaccines are available for Hepatitis B and HPV.

C. Go over each STI, using the information on pages 62-65.

D. To put the number of infections into context for your students, associate the numbers with a concept more familiar to them. Here are some examples:

- Find out how many students are in your school. Divide that number by the number of people infected with each STI per year. For example, if there are 2,000 students in your school, then the number of people that get Syphilis (7,000)[vii] each year is equal to 3.5 schools full of students and the number of people that get HPV (6.2 million)[viii] each year would be equal to 3,250 schools.
- Another example can be the size of cities and states. In the United States, Chlamydia is the most common bacterial STI, with an estimated 2.8 million new cases annually[vii]. This is roughly the population of the entire metro area (Minneapolis, Saint Paul and suburbs). HPV is the most common viral STI, with an estimated 6.2 million cases of genital HPV each year,[viii] roughly the population of the entire state of Minnesota and North Dakota combined.

vii. 31CDC (2003). STD Surveillance, 2003: Trends in Reportable Sexually Transmitted Diseases in the United States, 2003- National Data on Chlamydia, Gonorrhea and Syphilis. Retrieved September 2006 from http://www.cdc.gov/std/stats03/trends2003.htm

viii. CDC (2004). Genital HPV Infection - CDC Fact Sheet. Retrieved September 2006 from http://www.cdc.gov/std/HPV/STDFact-HPV.htm

9 Most commonly Spread STIs

STI	Pubic lice/crabs
Spread by	Contact with infected pubic hair, or by infected objects such as: bedding, towels, underwear, and swimsuits
Prevented by	Abstinence (however this will not prevent getting the STI through infected objects)
Symptoms/ looks like	Itching in genital area/Little bugs (visible)
Treatment	Must treat with special shampoo, which can be purchased over the counter. Wash all clothing and linens in hot water. Shaving will not get rid of Pubic Lice. Lice will crawl into the hair follicle and wait for hair to grow back
If left untreated	Secondary infection may occur as a result of broken skin from scratching infected area
Estimated number per year in the US	Data not available

STI	Trichomoniasis (Trich)
Spread by	Contact with infected body fluids
Prevented by	Abstinence, or a latex barrier such as condoms
Symptoms/ looks like	Frothy yellow, green, or gray discharge, odor, pain during urination or sex. Microscopic bugs
Treatment	Antibiotics
If left untreated	May increase risk of HIV infection; in females only, may cause changes to the tissue on the surface of the cervix
Estimated number per year in the US	7.4 million[ix]

STI	Chlamydia
Spread by	Contact with infected body fluids, may infect the throat
Prevented by	Abstinence, or a latex barrier such as condoms
Symptoms/ looks like	Abnormal discharge from vagina or penis, pain during urination. Often there are not symptoms
Treatment	Antibiotics
If left untreated	Females: May cause pelvic inflammatory disease (PID); PID can lead to infertility and cause damage to the fallopian tubes, which increases risk of ectopic pregnancy. Chlamydia can be passed to a child during childbirth. Males: May cause epididymitis, which can lead to infertility
Estimated number per year in the US	2.8 million[x]

ix. CDC (2004). Trichomoniasis - CDC Fact Sheet. Retrieved September 2006 from http://www.cdc.gov/std/Trichomonas/STDFact-Trichomoniasis.htm

x. CDC (2006). Chlamydia - CDC Fact Sheet. Retreived September 2006 from http://www.cdc.gov/std/Chlamydia/STDFact-Chlamydia.htm

STI	Gonorrhea
Spread by	Contact with infected body fluids (may infect the throat and the eyes)
Prevented by	Abstinence, or a latex barrier such as condoms
Symptoms/ looks like	Females: Pain or burning during urination, yellow or bloody discharge from vagina; Males: Burning during urination, yellowish white discharge from penis, painful or swollen testicles
Treatment	Antibiotics
If left untreated	Gonorrhea can spread to the blood or joints. This condition can be life threatening. Females: May cause pelvic inflammatory disease (PID). PID can lead to infertility and cause damage to the fallopian tubes, which increases risk of ectopic pregnancy. Gonorrhea can be passed to a child during childbirth. Males: May cause epididymitis, which can lead to infertility
Estimated number per year in the US	Over 700,000[xi]

STI	Syphilis
Spread by	Direct contact with a syphilis sore (also known as a chancre)
Prevented by	Abstinence, or a latex barrier such as condoms
Symptoms/ looks like	Occurs in 3 stages: Primary Stage- Painless chancre/sore (may be internal, especially in females); Secondary Stage- Rash (rough red or reddish brown spots, usually symmetrical); Late Stage- Damage to internal organs and central nervous system
Treatment	Antibiotics
If left untreated	May lead to brain damage, paralysis, blindness, or death
Estimated number per year in the US	Approximately 7,000 cases of Primary and Secondary syphilis[xii]

STI	HIV (Human Immunodeficiency Virus)
Spread by	Contact with infected blood, semen, breast milk or vaginal fluids
Prevented by	Abstinence, or a latex barrier such as condoms
Symptoms/ looks like	None specific to HIV; symptoms that may show can be related to many other illnesses
Treatment	There currently is no cure, but various medications are available to help improve some of the symptoms. Social, peer, and family support is also important to the health and overall well-being of a person living with HIV/AIDS
If left untreated	Further damage to immune system, which increases a person's risk for opportunistic infections
Estimated number per year in the US	40,000[xiii]

xi. CDC (2006). Gonorrhea - CDC Fact Sheet. Retreived September 2006 from http://www.cdc.gov/std/Gonorrhea/STDFact-gonorrhea.htm

xii. CDC (2004). Syphilis - CDC Fact Sheet. Retreived September 2006 from http://www.cdc.gov/std/Syphilis/STDFact-syphilis.htm

xiii. CDC (2006). A glance at the HIV/AIDS Epidemic. Retrieved September 2006 from http;//www.cdc.gov/hiv/resources/factsheets/at-a-glance.htm#3.

STI	Hepatitis B
Spread by	Infected body fluids and blood
Prevented by	Abstinence, or a latex barrier such as condoms; a vaccine is also available.
Symptoms/ looks like	Jaundice, fatigue, abdominal pain, fever, nausea and vomiting
Treatment	Medication; Vaccine available
If left untreated	Damage to the liver; scarring and progressive liver failure
Estimated number per year in the US	60,000[xiv]

STI	Herpes There are two strains of Herpes: HSV-1 (oral- cold sores) and HSV-2 (genital)
Spread by	Direct contact with herpes sores on the skin of an infected person; herpes can be spread at any time, but is most contagious when sore is present or right before outbreak. Oral herpes can be spread to the genital region, just as genital herpes can be spread to the mouth. Herpes can be spread to a baby during childbirth.
Prevented by	HSV-2: Abstinence or Latex barrier. Condoms reduce the risk of transmission, but do not eliminate it (condoms cover a limited area of skin, and the virus may be in areas not covered by the condom). HSV-1 can be spread by kissing. Kissing during non-outbreak times can reduce the risk of transmission.
Symptoms/ looks like	Painful, fluid-filled blister; the skin is often itchy or tingly before an outbreak occurs
Treatment	Over the counter medications can improve symptoms, but there is no cure. Prescription medication can help suppress outbreaks of genital herpes.
If left untreated	Recurrent outbreaks
Estimated number per year in the US	1 million[xv]

xiv. CDC (2006) Viral Hepatitis B. Retrieved September 2006 from http://www.cdc.gov/ncidod/diseases/hepatitis/b/fact.htm

xv. CDC (2000) Tracking the Hidden Epidemics: Herpes. Retrieved September 2006 from http://www.cdc.gov/std/Trends2000/herpes.htm

STI	Genital Warts (HPV)
Spread by	There are over 100 strains of HPV and about 30 of them are transmitted sexually. Some high-risk strains can cause cervical cancer in females; some low-risk strains can cause genital warts in males or females. Skin to skin contact, even with no visible warts, due to viral shedding; spread primarily through genital contact
Prevented by	Abstinence or Latex barrier. Condoms greatly reduce the risk of transmission, but do not always eliminate it (condoms cover a limited area of skin, and the virus may be shedding in those areas not covered by the condom).
Symptoms/ looks like	Warts may be small or large warts, raised or flat, single or multiple.
Treatment	Creams, freezing, or burning can get rid of warts (but not virus). A vaccine to prevent the strains of HPV that cause genital warts and cervical cancer was approved by the FDA in June 2006. It is recommended that the vaccine be administered to females between the ages of 9 and 26, prior to beginning sexual activity.
If left untreated	Certain strains can lead to cervical cancer in females.
Estimated number per year in the US	6.2 million[xvi]

xvi. CDC (2004). Genital HPV Infection - CDC Fact Sheet. Retrieved September 2006 from http://www.cdc.gov/std/HPV/STDFact-HPV.htm

Sexually Transmitted Infections

Activity 1: Spread the Word about STI transmission[xvii]

xvii. Adapted with permission from "The M&M Game" created by Planned Parenthood of Greater Iowa. Retrieved November 2006 from http://www.planned-parenthood.org/education-al-resources/teaching-ma-terials/the-mandm-game.htm

Time:

45-60 minutes, depending on length of post-activity discussion

Audience:

Age 12 and up

Materials:

3 x 5 index cards (one per student)
Pencil or pen (one per student)
Paper plates (one per student)
Brown lunch sack (one per student)
Plain M&Ms™ and Skittles™ - approximately one lb. of each for fifteen participants (OR all can be done with pieces of colored paper, just be sure to label the paper that is replacing the M&Ms™ with an "A" and the paper replacing the Skittles™ with a "B")
Birds & Bees Project brochure: "STIs: Am I at Risk?" (to be handed out to students at the end of the class) – see Appendix A for brochure

1. Preparation:

Separate candy into color groups, and put approximately 20-30 of the same color pieces in a bag for each participant so that each player begins the game with only one color of M&Ms™ or Skittles™ in their bag.

Code:

M&M™ Brown = Testing & Treatment
M&M™ Red = Condoms or Dental Dams
M&M™ Green = Trichomoniasis
M&M™ Yellow = Gonorrhea
M&M™ Blue = Chlamydia
M&M™ Orange = Syphilis
Skittles™ Purple = Pubic Lice (Crabs)
Skittles™ Green = HIV
Skittles™ Red = Hepatitis B
Skittles™ Orange = Herpes
Skittles™ Yellow = HPV

Note: Treatment does not mean cured. Certain STIs can be cured, while others cannot. However, even if an STI cannot be completely cured, in most cases it can be managed with certain treatments and medications.

2. Beginning the Game:

Ask students to get out something to write with and distribute a 3x5 card to each person. Paraphrase this introduction:

I have just given you a card. In a moment I am going to give you a paper sack containing M&Ms™, Skittles™ (or pieces of paper) but you can't eat the candy yet. The bag you will get will contain all the same color and type of candy. When I say "Go," look into your bag and see what color of M&Ms™ or Skittles™ you have and remember that color and type. Once you know what you started with in your bag, get up and try to get as many of your classmates' signatures on your card as you can and exchange candy before I call time. Go up to anyone in the group and ask them to sign your card, then place a couple of pieces of candy in each other's sack. Don't tell how many pieces you are giving each other and don't pay attention to the color of the pieces. (Depending on size of group, allow two to three min.)

3. Processing the Game:

a. After their time is up, have them return to their seats, and remind them not to eat the candy yet. Ask: Who has more than five signatures? Who has the most? The least?
b. Distribute the paper plates and have each participant separate their candy/paper into groups. No eating the candy yet!
c. Explain that for the purpose of this game, each signature represents a sexual contact and the candy/paper represents aspects of sexually transmitted infections. Be prepared for an uproar; lots of giggling, teasing, and comments.

d. Have the person with the most signatures stand up and read the names on his or her card out loud. Tell students to stand up if his or her name is read. Next, have one of the students who is standing read the names on his or her card out loud, and every student whose name is read should stand. Repeat this process until most or all of the students are standing.
e. Have students look around the room to see how many of their peers are standing, and how many are sitting down. What does this say about the transmission of STIs/HIV? (They can be spread very easily!)
f. Tell what each color represented. Write it on the board or have a chart prepared (but do not allow for it to be seen until this point).
g. Ask the students how many different colors and types of candy they have now compared to when they started the game. Do people with more names on their cards have more STIs represented in their candy? What does this say about transmission of STIs/HIV? (they can be spread easily, the more partners you have the more likely you are to contract and STI & you can have more than one STI at a time).
h. Tell students who have any red M&M's™ that they can sit down. For purposes of this activity, they used a condom or dental dam when engaging in sexually activity, and decreased their risk of infection.
i. Tell students who have any brown M&M's™ that they can sit down. They were tested for STIs and received treatment for any STI they may have contracted. Note: Remind students that all STIs can be treated and managed, but not all of them can be cured.
j. Have students look around the room again and ask what this says about condoms, dental dams and getting infections treated. (They are effective methods of staying healthy).
k. All the rest of the students can sit down at this point.
l. Students can now eat the candy!

4. Discussion Questions (additional questions for ages 15 to 18 are marked with *)

Note: You may prefer to make the discussion questions into a worksheet for students to complete on their own, and then go through it as a class.

a. Does sexual contact just mean sexual intercourse?
b. What does this tell us about the transmission of STIs?
c. Can a person have more than one STI at the same time?
d. After a person is treated for an STI, can they get it or another one again?
e. Do more partners = higher risk?
f. Can someone have an STI and not know it?
g. What lessens or eliminates risk?
h. What can a person do to prevent the spread of STIs?
i. Which behaviors or methods are the most effective? Least effective?
j. What is the difference between parasitic, bacterial and viral STIs?
k. Does treatment mean cured?
l. Can teens get confidential testing and treatment for STIs without their parent(s) permission? (Yes, see minors' consent information in Appendix B). *
m. How can young people help fight the spread of STIs? (make sure your students mention: serving as an accurate source of information, by being a responsible role model, and by encouraging others to protect themselves). *

5. Hand out Birds and Bees Project brochure to each student- Sexually Transmitted Infections: Am I at Risk?

THE BIRDS & BEES PROJECT

Pregnancy & STI Prevention

Lesson 4: Condom Negotiation

Introduction:

You might be asking yourself, "Do I really need to spend two entire days teaching my students about condoms?" We believe the answer is emphatically YES!

Latex and polyurethane (plastic) condoms are the only form of contraception that provides disease protection as well as pregnancy[i] protection. Whether or not the teens we are teaching are sexually active, it is essential that we break down the myths and embarrassment that are often associated with discussing, purchasing and using condoms to protect our youth from the sexually transmitted diseases that can have lasting impacts on their health and well-being. Additionally, many youth find it difficult to bring up the topic of using a condom with their partner or are pressured not to use condoms by their partners.

The lessons in this chapter were designed to help your students reduce the anxiety and to dispel myths they might have specific to condom use as well as provide them the information they need to become consistent and effective condom users when they become sexually active. By giving your students medically accurate information about condoms you are providing them with an essential tool they need to protect their health throughout their lives.

i. R. F. Carey, et al., "Effectiveness of Latex Condoms As a Barrier to Human Immunodeficiency Virus-sized Particles under the Conditions of Simulated Use," Sexually Transmitted Diseases, July/August 1992, vol. 19, no. 4, p. 230.

Fast Facts:

1. Using a latex condom is more than 10,000 times safer than not using a condom to prevent transmission of HIV.[ii]
2. Teaching about proper condom use and making condoms available doesn't encourage or result in increased sexual behavior.[iii]

Before you Begin:

1. We encourage teachers to demonstrate the proper steps to putting on a condom with a condom and penis model (your index and middle fingers, a banana, cucumber or test tube may be used if a penis model is not available). Make sure you practice demonstrating this activity with a condom and model before you actually attempt it in front of your students. If you are uncomfortable doing this demonstration, consider contacting a family planning clinic, The Birds & Bees Project, or another member of Minnesota's Sexuality Family Life Educators (SFLE) (see Appendix B) to perform the demonstration for you.

2. Since practice makes perfect, consider asking your local family planning clinic, school nurse or The Birds & Bees Project for a donation of condoms to your classroom so that you can have each student practice the activity along with you.

Goals:[iv]

After completing the lessons and activities in this chapter, participants will be able to:

1. Identify the steps involved in using lubricated, latex condoms correctly
2. Describe how the use of condoms is related to overall health and well-being
3. Identify strategies for negotiating condom use and demonstrate them through the use of accurate information

ii. R.F. Carey, et al, "Effectiveness of Latex Condoms As a Barrier to Human Immunodeficiency Virus-sized Particles under the Conditions of Simulated Use," Sexually Transmitted Diseases, 19, no. 4 (July/August 1992), p. 230. Retrieved September 2006 from http://www.siecus.org/pubs/fact/FS_truth_latexcondoms.pdf

iii. K. Coyle & D. Kirby "School-Based Programs to Reduce Sexual Risk-taking Behavior," Children and Youth Services Review 19, no. 5/6 (1997): 415-36. Retrieved November 2006 from http://www.aei.org/publications/pubID.17761/pub_detail.asp

iv. Adapted from National Standards, QTN Minnesota Benchmarks, and Sample Activities in Health Education: Kindergarten through Grade 10. Quality Teaching Network in Health Education and Physical Education, in cooperation with the Minnesota Department of Education. (2006).

v. Adapted from the Guidelines for Comprehensive Sexuality Education: Kindergarten-12th Grade, Third Edition. (2004). Sexuality Information and Education Council of the United States. Available online at www.SIECUS.org

Key Learning Points:[v]

- Condoms are available over the counter at a wide variety of locations, including pharmacies, grocery or convenience stores, as well as family planning or school-based clinics.
- Couples who want to reduce their risk for both pregnancy and STI/HIV need to use male or female condoms along with another effective method of contraception.
- It is important to learn how to use a condom effectively and consistently.
- Part of effective and consistent condom use is the ability to communicate effectively on behalf of your own health.
- People can find creative and sensual ways to integrate contraception into their sexual relationships.*

*Additional key learning points for ages 15 to 18

Condom Negotiation

Activity 1: Condom Line-Up[vi]

vi. Adapted from Advocates for Youth, "Condom Card Lineup." Copyright Advocates for Youth, www.advocatesforyouth.org

Time:

25 minutes

Audience:

12 and up

Materials:

Cards with one step on each card – DO NOT INCLUDE NUMBER ON CARD. CARDS ARE CURRENTLY IN THE CORRECT ORDER:

1. Discuss safer sex with partner
2. Decision to use condom
3. Obtain condom
4. Sexual arousal
5. Erection
6. Check the expiration date
7. Open package carefully
8. Squeeze the tip of the condom
9. Roll condom all the way to the base of the penis
10. Intercourse
11. Ejaculation
12. Hold onto the rim of the condom
13. Withdraw penis from partner
14. Remove condom from penis
15. Dispose of condom in trash (not toilet)
16. Loss of erection
17. Relaxation, talk, cuddle

Have students volunteer to put the steps in order. Hand out one card to each volunteer. Once students have put the steps in order, ask the class if the order is correct. Encourage lively discussion and group participation in correcting the order.

Note: the first and last steps of this process involve communication!

Finish the lesson by demonstrating the proper procedure for putting on a condom using a condom and model of a penis. If you are unsure of any of the reasons behind these steps, check with The Birds & Bees Project or your local family planning clinic for an explanation, or read the condom package insert.

Activity 2: Breaking Down Myths about Condoms

Ages:

12 and up, additional myths for students ages 15 to 18 are marked with a.*

Materials:

16 note cards

1. Prior to beginning the lesson write each myth on one side of a note card and leave the other side of the note card blank.

2. Pass out one or two note cards to each student or group of students. For younger audiences you may want to begin with a brief discussion about what a myth is versus what a fact is.

3. Ask the students to research the fact associated with this myth on the Internet or in the library or have them come up with what they think the fact might be on their own if the Internet or other resources are not immediately available.

4. Have them write their answers on the other side of the note card when they are finished with their response (approximately 10 min). While they are doing this monitor their progress and redirect them if they are focusing more on the myth than on the fact that counteracts it.

5. Ask each group to read their myth and fact aloud and correct any misinformation or provide more context as necessary. Ask one person in the group to correct the information on the back of the note card as well.

6. This activity may be modified as a homework activity by asking all of the students to respond to all of the myths. However, make sure to provide enough class time to go over all of the myths and discussion questions.

7. You may also have additional myths you would like to add to this list based on prior class discussions or student questions. It is often effective to hang your myth/fact cards somewhere in your classroom so that students can look at them throughout the remainder of the year. Adjust how much of the following information you provide based on age group.

Myth #1:

Condoms don't work[vii] In one year with perfect use (meaning couples use condoms consistently and correctly at every act of sex), 98% of women relying on male condoms will remain pregnancy-free. In one year with perfect use, 95% of women relying on the female condom will remain pregnancy-free. By comparison, only 15% of women using no method of contraception in a year will remain pregnancy-free. Illustrate the effectiveness of condoms by having 2% of the student in the class stand up (In a class size of 50 or less this would be zero students) versus 85% of the class stand up (in contrast, this would be 42 students in a class of 50).

Myth #2:

Condoms frequently break. Several studies clearly show that condom breakage rates in this country are less than 2%[ix]. Most of the breakage is due to incorrect usage rather than poor condom quality. Using oil-based lubricants can weaken latex, causing the condom to break. In addition, condoms can be weakened by exposure to heat or sunlight or by age, or they can be torn by teeth or fingernails during the opening and application process. To reduce breakage, couples should use a water-based lubricant or buy lubricated condoms, check the condom expiration date (never use an expired condom), keep condoms in a cool, dry place and never open a condom package with teeth.

viii. Hatcher RA et al. Contraceptive Technology, 18th rev. ed. New York: Ardent Media, 2004.

ix. CDC MMWR Weekly (1993). Update: Barrier Protection Against HIV Infection and Other Sexually Transmitted Diseases. Retrieved September 2006 from http://www.cdc.gov/MMWR/preview/mmwrhtml/00021321.htm

Myth #3:

HIV can pass through latex condoms. A commonly held misperception is that latex condoms contain "holes" that allow passage of HIV. Laboratory studies show that intact latex condoms provide a continuous barrier to microorganisms, including HIV, as well as sperm.

*Myth #4:

All types of condoms protect you from STIs as well as prevent pregnancy. Latex condoms are the most widely available and used condom due to their ability to protect against both STIs/HIV and pregnancy, as well as their affordability. A second type of condom is the polyurethane condom. When used correctly, polyurethane condoms are just as effective as latex condoms for preventing pregnancy and the transmission of STIs/HIV; however, polyurethane condoms are less elastic and looser-fitting, making them slightly more likely to break or slip off under typical use scenarios. (They are typically used by people who are allergic to latex). Additionally, polyurethane condoms tend to cost moderately more than latex condoms. The third type of condom is a lambskin or "natural" condom. This is the oldest form of condom and it is made from the intestinal membrane of a lamb. Small pores make lambskin condoms ineffective in protecting against viruses that cause STIs, but they do protect against pregnancy since the pores are too small for sperm to pass through.

Myth #5:

Condoms are difficult to find and can be expensive to buy. Condoms are available at numerous, convenient locations including: drug stores, convenience stores, family planning clinics, STI clinics, at the local health department, and even at some schools. They are very low in cost, from free to $10 per package and no prescription is needed to get condoms.

Myth #6:

You have to be 18 in order to buy condoms. Anyone, of any age, can buy condoms. In 1997, the Supreme Court ruled that no state could bar minors from purchasing condoms.

Myth #7:

Condoms are 100% effective in preventing pregnancy. Since condoms are not 100% effective at preventing pregnancy it is best, whenever possible, to use a condom in combination with another birth control method. A condom should be at least one of the two methods people use when trying to prevent pregnancy since it is the only method that is also effective at protecting against STIs/HIV.

Myth #8:

Condoms prevent sexual pleasure for males. Condoms are thin and don't prevent pleasure. Additionally, worrying about STIs/HIV or potential pregnancy is a lot less pleasurable than wearing a condom.

Myth #9:

Double-bagging (or using two condoms) is more effective than using just one. Most people believe that if one is good then two is better; however, this is NOT TRUE. Two condoms create a lot of friction, which can make the condoms break more easily. People should use one lubricated latex condom for vaginal or anal intercourse.

***Myth #10:**

You can reuse a condom if you have sex more than once within a short period of time with the same person. Using the same condom twice can be very risky. Sperm and fluids containing STIs can remain on the condom if used a second time. Additionally, condoms suffer wear and tear after one use and thus are much more likely to break if used a second time. Condoms should be discarded immediately after single use or if an erection goes flaccid before ejaculation.

***Myth #11:**

If you put the condom on upside down, and have not had intercourse yet, it is still good to use. Just flip it over and put it on properly. Sperm and fluids containing STIs/HIV are present in high concentrations in male pre-cum, which is most likely on the tip of the penis at the time a condom is applied. If you apply the condom upside down and then flip it over to apply it properly, you are exposing your partner to the sperm and fluids found in the pre-cum. Therefore, a condom should be thrown away and a new condom should be used if the condom was put on upside down initially. Note: This myth is particularly helpful to demonstrate for students with a condom and penis model.

***Myth #12:**

You should always keep a condom in your wallet or purse. Direct sunlight or extreme temperature can make a condom significantly more likely to break or tear. A wallet is exposed to vast changes in temperature depending on the weather and your body heat. If you are planning to have sex, you may put a condom in your wallet, purse or pocket for that evening. However, if it is not used take it out and store it with your other condoms in a cool, dark place where the temperature does not change greatly. Also be aware that pens in purses and backpacks can damage condoms.

***Myth 13:**

Condoms ruin the moment. Condom use can be incorporated into your sexual experience in creative and sensual ways. Condoms now come in a range of different colors, flavors, styles and sizes (for example, glow-in-the-dark or strawberry flavored condoms). These differences allow partners to experiment with different types for purposes of pleasure and fun. Putting a condom on your partner can be a sensual way to incorporate condom use into foreplay and show your partner respect. Wearing a condom can make the sexual experience even more satisfying, when both partners see the condom as a symbol of respect for the other's health and well-being.

***Myth 14:**

If a woman has a condom she must be promiscuous. Carrying a condom says nothing about a person's promiscuity. In reality, people (no matter what sex) who have condoms show that they are prepared to have safe sex when the time is right for them. They are taking responsibility for their own health and well-being. Both women and men should know how to put condoms on properly and should be willing to purchase condoms if they are in a sexual relationship. Keep in mind that both partners are responsible for preventing pregnancy and STI transmission.

Myth 15:

It's OK to flush condoms down the toilet. Flushing condoms down the toilet is a bad idea. Condoms can clog your plumbing or end up in the water supply. The best place for a condom is in the garbage. Latex is not biodegradable, so it is best to throw your condom into a trashcan by itself or wrapped in toilet paper to be more discreet. Also, make sure that condoms are kept away from small children, as they can be a choking hazard.

Myth 16:

Distributing free condoms to teens makes teens more likely to have sex. Studies show that condom availability programs do not encourage teens to initiate sex and do not cause sexually active teens to have sex more often or with more partners.[x,xi,xii,xiii] Condom availability programs reduce the barriers—financial, logistical, and social—that deter sexually active teens from using condoms.[xiv] The American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American Medical Association, and Institute of Medicine all support making condoms available to teens. In addition, the Center for Disease Control has included condom availability among an array of effective approaches to reducing HIV and other STIs.

Discussion questions to be used at the end of the activity:

- If you are uncertain about whether or not something you hear about condoms is a myth, where can you go to get medically accurate information?
- Where could someone go if they wanted to purchase a condom? Where could someone go to get free condoms?
- What makes talking about condoms difficult?
- What can you do to make talking about condoms easier?
- *Do you think it is important to have a condom on hand even if you don't think you will be engaging in sexual activity?

x. Guttmacher S et al. Condom availability in New York City public high schools: relationships to condom use and sexual behavior. American Journal of Public Health 1997; 87:1427-1433.

xi. Blake SM et al. Condom availability programs in Massachusetts high schools: relationships with condom use and sexual behavior. American Journal of Public Health 2003; 93:955-962.

xii. Furstenberg FF et al. Does condom availability make a difference? An evaluation of Philadelphia's health resource centers. Family Planning Perspectives 1997; 29:123-127

xiii. CDC. Condom availability as a prevention strategy. CDC Update 1997 (February):[1-2].

xiv American College of Obstetricians and Gynecologists. Condom availability for adolescents. Journal of Adolescent Health 1996; 18:380-383.

Activity 3: Negotiating condom use with your partner[xv]

xv. Adapted from the Sexuality Information and Education Council of the United States, 130 West 42nd Street, Suite 350, New York, NY 10036, www.siecus.org

Now that your students understand the truth behind the myths associated with condoms and how to use a condom properly it is important that they practice how to discuss the use of condoms with a partner so that they can feel confident and prepared to advocate for their health now or in the future when they decide to have sex.

Audience:

12 and up with different instructions

Time required:

Ages 12 to 15: 25 minutes, ages 15 to 18: 45-60 minutes, additional instructions and questions for teachers instructing students ages 15 to 18 are marked with a *

Materials:

Newsprint and markers, or chalkboard

Procedure:

1. Begin the class by having the students watch the short clip "Jump Partners" by the Youth Performance Company (2.5 minutes). Following the video ask your students:
   a. What message was this video trying to communicate to teens? What were they using the word "jump" in place of in the skit? How about "parachute?"
   b. How was the guy in the skit treating the girl in the skit? (Answer: pressuring her to do something she did not want to do, pressuring her to have sex without a condom, not respecting her, etc.)

c. How do you think the girl handled the situation? (If it is not brought up, make sure to point out that it was good that she decided not to have sex with him without a condom and that he did not respect her or her health).

2. Have your students watch the video again now that they have this knowledge. Ask them to listen for the comments that "the guy" makes to try to convince "the girl" to jump without using a parachute (have sex without using a condom).

3. Once the video is over tell the students that most sexually active young people know they should use condoms to protect themselves from pregnancy and STIs, but many find it hard to convince a partner or are uncomfortable bringing the topic up when the time comes.
   a. Ask participants to list the things the guy in the video was saying to the girl to try to convince her to have sex without a condom (I'm ready to jump/have sex right now, I can't wait and I don't have a parachute/condom with me, You can't get hurt/pregnant/an STI the first time, Parachutes/condoms decrease the thrill/pleasure factor, I thought we had something special, etc.).
   b. Continue by having your students brainstorm additional things a guy or a girl might say or other reasons why it might be hard to convince a partner to use a condom. Make a list on newsprint or the chalkboard. Acknowledge that many students are not sexually involved but that this information may be useful to them later or to share with their friends who are sexually involved (Additional answers may include but are not limited to: Don't worry, I'll pull out before I cum; It will feel better if we don't use a condom; It will interrupt the mood if we have to stop and put on a condom; I don't want anything between us; Do you think I have an STI?, etc.).

   c. This step is only for teachers working with students age 12 to 15. As a large group ask them to come up with some ways that they could respond to statements such as these if their partner made them. Make sure to mention abstaining from having sex with a partner who is not willing to respect your wishes if it is not brought up. You may have them watch the video for a third time, paying special attention to the girl in the video and how she responds to the guy's pressure to get the conversation started.

Note: Numbers 4-7 are for those teaching students ages 15 and up. Please skip to number 8 if you are teaching students ages 12-15.

4. *Divide the class into groups of three to four students and assign at least one refusal line from the list created or the options given to each group (if you have a large number of participants, you may give the same refusal to more than one group. If you have a small class, you may give each group more than one refusal.)

5. *Next ask each group to generate at least three condom-friendly responses that could be used if their partner was pressuring them to have sex without a condom. Tell them that they will be doing a role-play of their refusal and favorite response. Give them about 10 to 15 minutes to work on the role-play and responses.

A list of condom-friendly answers is as follows:

- "Let's go get some condoms together."
- "I care about us too much to put either one of us at risk."
- "There are lots of ways to make each other feel good without doing things that need a condom."
- "You are important to me and I want us to be safe."
- "If we use the condom we don't have to worry about pregnancy or STIs."

- "If we use the condom I'll be more relaxed and I'll enjoy myself more."
- "When we're dressed and make out, it feels good. So how can a little piece of latex ruin the feeling."
- "I hear that condoms can make sex last longer."
- "I can't enjoy intercourse unless we use a condom."
- "Let's not have intercourse. We can do other things to be close."

6. *Bring the entire group together, and ask each small group to select two people who are willing to role-play the best refusal and the response they came up with. After they role-play the situation write the responses on the board that they used as well as the two responses they did not use. Ask the large group to give feedback to the small groups using these questions:
   a. What did you think of the responses the group selected for this refusal?
   b. What do you like about the response they wrote for themselves?
   c. How would you feel saying this to a partner?
   d. Would it be convincing?
   e. What should a person do if he or she uses all of the responses and their partner still refuses to use a condom?
   f. What are some of the ways that a person can bring up condom use with their partner?

7. *Provide the additional ideas listed to the students if they do not come up with these answers on their own.

8. Summarize by saying that insistence on condom use is a very important skill that takes practice. Remind young people that keeping healthy and safe is important. If they are sexually involved, or when they become sexually involved, they must insist on condom use. If a partner insists on not using a condom, a person should choose to abstain from intercourse or engage in sexual behaviors where they are not at risk of pregnancy or STI infection.

THE BIRDS & BEES PROJECT

Lesson 5: Emergency Contraception

Introduction:

Emergency Contraception (EC) is an effective method of post-coital pregnancy prevention for use in emergency situations, that is underused by both teens and women. According to the New England Journal of Medicine, EC could prevent as many as 1.7 million of the approximately three million unintended pregnancies each year if more women and teens understood how to access and use it effectively. Since its first availability in 1998, EC has been the subject of much political and medical debate, largely due to the confusion and misconceptions that surround it. Despite all the media attention, many people are still unaware of its existence. Additionally, those who have heard about it are often unclear about what it is, how it works, and where or how to get and use it. The following lesson has been designed to cover the basics of EC and to dispel myths your students might have about it.

Fast Facts:

1. The FDA states that EC is safe and effective.[i] The Society for Adolescent Medicine,[ii] The American College of Obstetricians and Gynecologists,[iii] The American Medical Women's Association,[iv] The American Medical Association,[v] U.S. Department of Health and Human Services,[vi] and the World Health Organization[vii] all support access to EC.

2. According to a 2005 statewide survey of MN pharmacies, 71% of survey respondents indicated that they stock EC in their pharmacy.[viii]

i. Government Printing Office. Prescription Drug Products: certain combined oral contraceptives for use as postcoital emergency contraception: notice. Federal Register 1997(February 25); 62:8609-12.

ii. Society for Adolescent Medicine. Provision of emergency contraception to adolescents: position paper of the Society for Adolescent Medicine. Journal of Adolescent Health 2004; 35:66-70.

iii American College of Obstetricians and Gynecologists. Emergency oral contraception. ACOG Practice Patterns 1996; No. 3:1-8.

iv. American Medical Women's Association. Position Statement on Emergency Contraception. Alexandria, VA: Author, 1996.

v. American Medical Association. Access to Emergency Contraception [Report of the Council of Medical Service, CMS, Report 1-1-00] Chicago, IL: Author, 2000.

vi. U.S. Department of Health and Human Services. Emergency Contraception [Memorandum: OPA Program Instruction Series, OPA 97-2] Rockville, MD: Author, 1997.

vii. World Health Organization. Improving Access to Quality Care in Family Planning: Medical Eligibility for Initiating and Continuing Use of Contraceptive Methods. [WHO/FRH/FPP/96.9] Geneva: WHO, 1996.

viii. NARAL Pro-Choice Minnesota Foundation (2005). Statewide survey of MN pharmacies and EC. info@prochoiceminnesota.org

ix. Adapted from National Standards, QTN Minnesota Benchmarks, and Sample Activities in Health Education: Kindergarten through Grade 10. Quality Teaching Network in Health Education and Physical Education, in cooperation with the Minnesota Department of Education. (2006).

x. Adapted from the Guidelines for Comprehensive Sexuality Education: Kindergarten-12th Grade, Third Edition. (2004). Sexuality Information and Education Council of the United States. Available online at www.SIECUS.org

Before you Begin:

1. Visit www.go2planb.com . Plan B has an educational materials section on their website that includes informational brochures on all types of birth control methods as well as posters they will provide free of charge (available in English and Spanish).

2. At the time of printing of this guide (2006) the FDA had recently announced that EC was approved to go over the counter for women ages 18 and over. Please visit our website at www.birdsandbees.org before beginning this lesson for an update on the status of over-the-counter EC and the impact this access has on teens.

Goals:[ix]

After completing the lessons and activities in this chapter, participants will be able to:

- Distinguish between myths and facts related to Emergency Contraception (EC).
- Identify how EC works, how it is different from birth control pills and how to access it.
- Analyze the influence of culture, media and technology on access to EC.*

Key Learning Points:[x]

- Emergency Contraception pills contain hormones that work the same way ordinary birth control pills do to prevent pregnancy, except they are designed to be taken after sexual intercourse. Note that people should not use EC as a "substitute" for regular birth control.

- Teens ages 17 and under who have had unprotected vaginal intercourse or whose contraceptive method failed can obtain emergency contraception from their health care provider or pharmacist. Males or females who are 18 and older can purchase EC over the counter at most local pharmacies with a government issued ID.
- Emergency contraception should not be used as a primary method of birth control.
- Emergency contraception, when taken up to 72 hours (three days) after vaginal intercourse can prevent pregnancy. However, the sooner EC is taken, the more effective it is.
- *Emergency contraception is a high dosage of birth control pills.
- *Emergency contraception is NOT a method of abortion.

* Additional key learning points for students ages 15 to 18

Activity 1: Myths and Facts about Emergency Contraception

Time:

40 minutes

Audience:

ages 12 and up, additional questions for ages 15 to18 indicated with *

Materials:

Paper
Markers
Two signs – "Myth" and "Fact" hung up on opposite sides of the room
Birds & Bees Project "Three Little Pills" card (see Appendix A)

Activity:

1. Ask the group which of the contraceptive methods discussed in the contraceptive lesson is the only one that can be used to prevent pregnancy after a couple has had unprotected sexual intercourse, if a contraceptive method fails, or if a young woman has been raped.

2. Explain that many people, even adult women and some health care providers either do not know about emergency contraception, or have some misperceptions about it.

3. Ask the group to stand. Tell them that you are going to read a series of statements about emergency contraception. If they believe the statement is true, ask them to move to stand under the "Fact" sign. If they believe the statement is false, ask them to stand under the "Myth" sign. Check to see if the students have any questions. (For students ages 12 to 15 you may want to provide an "unsure" option).

4. Read the statements listed under "Myths & Facts about EC" on pages 93-96. Ask the group standing under the incorrect sign first to explain why they chose that answer. Then ask the group standing under the correct answer to explain why they chose their answer. Be sure to gently dispel any continuing myths. The goal of the activity is to become more educated about the topic, not to embarrass anyone. Stress that part of doing this activity is to show how many myths exist specific to EC and that you don't expect students to get all of the answers correct.

5. After the activity, ask everyone to take a seat. Ask what they learned about EC that surprised them. Do they know anyone in their family, school, or community that knows about EC or where to get it?

6. Brainstorm the benefits of EC and also some of the concerns about it. See if the group can reach the consensus that EC is an important resource for all young people to know about.

7. Divide the group into smaller groups. Give each group a sheet of paper and a marker and ask them to come up with ways to raise awareness about EC among teens and ways to increase access to EC.

8. * For ages 15 to 18, hand out the Birds & Bees Project "Three Little Pills" card. Go over it with your students to help them distinguish between birth control pills, EC and the abortion pill (RU-486).

9. **Discussion Questions:**
   - Do you think it is important for all teens to have accurate information about emergency contraception? Why or why not?
   - What are the benefits to EC, and what are the drawbacks?
   - How is EC different from the birth control pill?

10. For students ages 15 to 18, ask your students to research the Federal Drug Administrations decision to make Emergency Contraception available over the counter. Have your students write a brief paper about their research discussing whether or not they think that emergency contraceptive pills should be available over the counter to teens under the age of 18 as well.

xi. Adapted from Advocates for Youth, "Facts about EC – True or False." Copyright Advocates for Youth, www.advocatesforyouth.org

xii. Task Force on Postovulatory Methods of Fertility Regulation. Randomised controlled trial of levomorgestrel versus the Yuzpe regimen of combined oral contraceptives for emergency contraception. The Lancet 1998, 352: 428-433. Retrieved November 2006 from http://www.backupyourbirthcontrol.org/documents/toolkit/FactSheet_EC-PlanB.pdfv

Myths and Facts about Emergency Contraception (EC)[xi]

1. **Emergency contraception is a type of birth control that must be used before a person has sex.**

   A: **Myth.** Emergency contraceptive is used after a person has unprotected sexual intercourse.[xii]

2. **Emergency contraceptive pills can reduce a woman's risk of pregnancy by 89 percent when taken within 72 hours of unprotected sexual intercourse.**

   A: **Fact.** Studies have shown Plan B (the brand name for EC) to be 89% effective in preventing pregnancy if taken within 72 hours (three days) after unprotected sexual intercourse. Recent research suggests that EC may be effective up to 120 hours (five days) after sexual intercourse. However, the sooner a woman takes it, the more effective it is. Therefore, a woman or teen should take EC as soon as they can in order to have the greatest chance of preventing pregnancy.

3. **Emergency contraception can be used in a number of circumstances.**
   A: **Fact.** It may be used if a couple has had unprotected sexual intercourse. It also works if a couple experiences contraceptive failure—for example, if a condom breaks, if a woman misses two or more of her pills, forgets to change her patch or ring, gets her Depo shot late, or if her diaphragm slips out of place during sex. Women can also use emergency contraception in the event of rape or sexual assault.

4. **Emergency contraception is expensive.**
   A: **Myth.** Emergency contraceptive pills cost between $10.00 and $40.00. Additionally, health insurance may cover the cost and many teen clinics charge teens on a sliding fee scale.

5. **Emergency contraception may be harmful to teenage women.**
   A: **Myth.** When used as directed, emergency contraceptive pills are a safe and effective option for teenage women. In fact, research shows that emergency contraceptive pills are safer than aspirin.[xiii] Furthermore, EC will not harm the pregnancy if a woman is already pregnant when she takes them. However, EC should not be used as a primary form of birth control.

6. **Emergency contraceptive pills protect against sexually transmitted infections (STIs), including HIV.**
   A: **Myth.** Emergency contraception prevents pregnancy, not STIs. Using condoms every time a person has intercourse is the best way to prevent STIs.

7. **A teenager has the legal right to obtain emergency contraception without her parent's permission.**
   A: **Fact.** Teens in every state have the right to obtain emergency contraception without parental consent or notification.

xiii. AMA, Policy H-75.985, August 2005; APHA et al., Letter to Diane Stuart, 06 Jan 2005; Center for Reproductive Rights, Emergency Contraception is Safer than Aspirin, List of Petitioners, February 2001.

8. **Teens can purchase EC over the counter at most pharmacies.**
   A: **Myth.** People ages 18 and older can purchase EC over the counter; however, teens ages 17 and under may only purchase EC with a prescription.

9. **If you are age 17 or younger, EC can only be obtained from your family doctor.**
   A: **Myth.** There are numerous ways to obtain a prescription for EC. Call the National EC Hotline at 1-800-NOT-2-LATE to locate the nearest doctor, nurse practitioner or health clinic, or visit www.not-2-late.com.

10. **It is possible to have a prescription for emergency contraception on hand before a person needs it.**
    A: **Fact.** Because emergency contraception should be taken within 120 hours (three days) after unprotected intercourse, medical experts encourage women to obtain and fill a prescription or buy EC over the counter so that she has it on hand if the need for EC arises. For people who keep EC on hand, it is important to check the expiration date before using the pills to make sure the expiration date has not passed.

11. ***Emergency contraception does not have any side effects.**
    A: **Myth.** EC has similar side effects to other forms of hormonal birth control. Some women taking emergency contraception may feel nauseous, dizzy, or tired. Some women vomit and have a headache or sore breasts. These side effects are temporary and should last less than a day or two.

12. ***Emergency contraceptive pills can cause abortion.**

A: **Myth.** Emergency Contraceptive pills work by preventing pregnancy, not by causing abortion. EC will not harm the pregnancy if a woman is already pregnant when she takes them.

13. ***It is required by law that physicians offer Emergency Contraception to victims or rape.**

A: **Myth.** Standards of emergency care established by the American Medical Association (AMA) require that rape survivors be counseled about their risk of pregnancy and offered emergency contraception. However, in Minnesota there is no law that states physicians are required to offer information about EC to their patients.

Chapter 3 - Unplanned Pregnancy Options

Introduction:

As educators we are reminded daily of what it was like to be a teenager. We are aware of the feelings of invincibility ("An unplanned pregnancy could never happen to me") and certainty ("I don't know how she can put her child up for adoption; I would never do that") that many teens bring to complex and emotional issues such as unplanned pregnancy. We also know the reality: teens do get pregnant and dealing with an unplanned pregnancy is never simple.

The following lessons have been designed to help your students reflect on the full range of feelings and obstacles that teens often encounter when dealing with an unplanned pregnancy. Teaching teens about these options can open their eyes to the complexity of this issue, help them clarify their own values and provide additional motivation to avoid pregnancy. Educating teens on all three options - teen parenting, adoption and abortion, shows teens that we respect them and their ability to make decisions.

The political debate surrounding teen pregnancy can make presenting this topic to teens particularly challenging, given its potential for emotional reactions. To help make this task easier, we have chosen activities and included tips to help your students utilize valid health resources, understand the impact of their choices and analyze how the influence of others impacts their decisions. Additionally, the introductory and ending exercises focus on supporting others when making an unplanned pregnancy decision, even if it is not the same decision that the teen would choose for herself/himself. We have found this approach helps reduce the stigma associated with all of these choices and allows students to focus on how unplanned pregnancy impacts their health.

The Birds & Bees Project staff are always available to address any questions or concerns you may have as you teach this challenging issue. Don't hesitate to contact our education staff by phone 612-821-9795, email pcr@birdsandbees.org or via our website: www.birdsandbees.org with your questions.

Before you begin:

1. Take a few minutes before beginning the lesson to acknowledge that each one of your students has his or her own set of values, beliefs, and opinions that are based on a combination of factors such as their religion, culture, gender, personal life experiences, and family. Taking the time to have a brief talk about respecting the opinions of others, especially when discussing controversial topics like abortion, will help create a safe and comfortable learning environment for everyone.

2. Remind students that when talking about unplanned pregnancy options, there is no right or wrong, and no good or bad choice. The fact of the matter is that every unplanned pregnancy has its own circumstances, and there is no easy, one-size-fits-all solution. The individuals in the situation must evaluate the costs and benefits of each option before making the decision that is best for them.

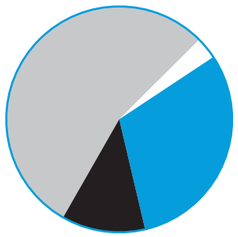
3. Let students know that the point of sharing this information with them is not to advocate for one option or another, but to simply share the facts about each choice with them in a non-biased format. This gives the students a knowledge base from which they can formulate their own thoughts and opinions.

Fast Facts:

1. Every day in Minnesota, 19 teenagers become pregnant.[i]

2. Teenage pregnancy, birth and abortion rates in the United States have been declining for a decade. Nevertheless, the United States continues to have a substantially higher teenage pregnancy rate than most other developed countries—for example, nearly twice the rate of Australia or Canada and more than four times the rate of France.[ii]

3. Of U.S. teens who face an unplanned pregnancy, approximately 56% choose to parent[iii], 29% choose to have an abortion, 1% choose to place the child for adoption[iv], and 14% experience a miscarriage.[v]



56% Parent
1% Place for adoption
29% Abort
14% Miscarry

i. MOAPPP (2005). 2005 Minnesota State Adolescent Sexual Health Report. Retrieved September 2006 from http://www.moappp.org/Documents/2005AdoHealthReport.pdf

ii. Singh S and Darroch JE, Adolescent pregnancy and childbearing: levels and trends in developed countries, Family Planning Perspectives, 2000, 32(1):14–23.

iii. Percentage of teens who parent was calculated by subtracting the teen adoption rate, found in reference iv, from the teen birth rate, found in reference v.

iv. Moore, K. A., Miller, B.C., Sugland, B.W., Morrison, D.R., Glei, D.A., and Blumenthal, C. (1995). Beginning too soon: adolescent sexual behavior, pregnancy, and parenthood. Executive Summary. Washington, DC: ChildTrends.

v. Henshaw, S. "U. S. Teenage Pregnancy Statistics With Comparative Statistics for Women Aged 20–24" downloaded 9/14/06 at http://www.guttmacher.org/pubs/teen_stats.pdf.

vi. Adapted from National Standards, QTN Minnesota Benchmarks, and Sample Activities in Health Education: Kindergarten through Grade 10. Quality Teaching Network in Health Education and Physical Education, in cooperation with the Minnesota Department of Education. (2006).

vii. Adapted from the Guidelines for Comprehensive Sexuality Education: Kindergarten-12th Grade, Third Edition. (2004). Sexuality Information and Education Council of the United States. Available online at www.SIECUS.org

Goals:[vi]

After completing the lessons, participants will:

1. Comprehend how parenting, adoption, and abortion are options that a teen must decide among when faced with an unplanned pregnancy.

2. Demonstrate the ability to practice effective interpersonal communication in discussing unplanned pregnancy.

Key Learning Points:[vii]

- People should carefully evaluate the consequences, advantages and disadvantages of each possible unplanned pregnancy choice before they make a decision.
- Values influence a person's most important decisions.
- Teenagers facing an unintended pregnancy can and should talk with their parents, other family members, religious leaders, counselors, healthcare providers, or other trusted adults.
- * Making a decision about an unplanned pregnancy may be difficult because of societal and cultural pressures.
- * In some situations, women have the legal right to make the final decision about an unplanned pregnancy.

* additional learning points for ages 15 to 18.

Unplanned Pregnancy Options

Overview Activity: Tough Choices

Time:

45 minutes

Audience:

12-18 years old, questions with * are additional information for students ages 15 and older.

Materials:

Chalkboard or whiteboard

Birds & Bees Project brochure- "I'm Pregnant, What can I do?" (see Appendix A)

Activity:

1. Read the entire Unplanned Pregnancy chapter before you begin. Since this is an overview activity, it is helpful to have background on all of the options as well as be able to tell students what you will be focusing on in greater depth in future class discussions.

2. Begin the activity by laying ground rules about respecting the diversity of opinions in the classroom (see the "Before you begin" section on page 99.

3. Ask students what a young woman's options are if she experiences an unplanned pregnancy (you can refer back to the Plan ABC activity if students get stuck). As they list "teen parenting," "adoption," and "abortion" write them on the board horizontally next to one another - leaving enough room underneath each option to create a list of 4 to 5 "pros" and "cons" for each option.

4. Focus on Teen Parenting first. Ask your students what percentage of teens that face an unplanned pregnancy choose to parent, give them time to guess and write the correct percentage (56%) on the board next to the phrase "Teen Parenting".

5. Provide your students with a brief overview of Teen Parenting by covering the points in "Tough Choices, Teaching Points" on page 105.

6. Next, make a "pros" and "cons" column under the word "Teen Parenting." Ask the students for reasons why a teenager would choose to parent. Write all of their responses on the board in the "pros" column. Then ask the students why a teenager would not choose to parent, and write their responses on the board in the "cons" column. Write down as many responses as the students give, but be sure that the lists are equal in number to ensure a non-biased activity. Feel free to give students hints if they are having a difficult time coming up with 4 to 5 answers. See a sample of typical answers given by students on page 107.

7. Repeat steps 4 - 6 for "open adoption" and "abortion."

8. Go over Discussion Questions with your class and hand out Birds & Bees Project brochure, "I'm Pregnant, What Can I Do?" – see Appendix A for brochure

Notes: Sometimes students will use inappropriate wording when giving responses. When this occurs, rephrase the response in a more positive manner. For example, when listing reasons why a pregnant teen would not choose to have an abortion, a student may respond, "abortion is murder." This can be rephrased as, "do not believe in abortion" or "think abortion is wrong." Additionally, it is common for students to bring

up examples that work for all three choices; however, students don't necessarily view them as so. The two most frequent examples of this are "following my beliefs" in the "pro" column (usually brought up in terms of adoption or parenting) or "guilt or regret" in the "con" column (usually brought up in terms of adoption or abortion). It is important to point out that "following my beliefs" could fit into any of the "pro" columns or "guilt" can fit into any of the "con" columns, as your students may not be able to make this connection on their own.

Discussion Questions:

Additional Questions for Ages 15 to 18 noted with *

1. What do teen parenting, adoption and abortion all have in common? There are many answers to this question but be sure to communicate to students that teen parenting, adoption & abortion are all tough and individual choices?

2. Have the students focus on the "con" column in Teen Parenting. Ask them how might this column look different if the class was focusing on a woman experiencing a planned pregnancy at 30.

3. Have students focus on all three columns again. Ask the students if they would have created a different list of pros and cons if they found out that the teen was a victim of sexual violence such as rape or incest. If yes, how might their lists be different?

4. Ask them if they had to make their own lists would it look different (just have them answer yes or no – but don't have them comment on how)? What factors might influence what is on your list versus another person's list (age, circumstance surrounding pregnancy, religion, culture, gender, personal life experiences, etc.)?

5. *What types of pressures might influence the decisions teens make? (A: parents/partner support her decision, misinformation or not having full knowledge about all of the options, peer pressure, etc.)

6. *Who has the right to make the final decision about what happens to the pregnancy? (The teen or woman who is pregnant).

7. Conclude by asking, how do you think you should treat someone who makes a decision different than your own?

Tough Choices Teaching Points – Brief Overview

Teen Parenting:

- Approximately 56% of teenagers who face an unplanned pregnancy in the U.S. choose to become a teen parent.
- Parenting is a life-long commitment. The responsibilities of parenting remain long after the child is no longer a baby.
- Raising a child for the first year, on average in Minnestoa, costs $26,965.[vii]

viii. MOAPPP (2005). Dollars and Sense Fact Sheet. Retrieved September 2006 from http://www.moappp.org/Documents/Dollar-sAndSense.pdf

Adoption:

- Approximately 1% of teenagers who face an unplanned pregnancy in the U.S. choose to make an adoption plan.
- There are two main types of adoption in Minnesota: open and confidential. Open adoption allows teens the option to see the child again after placement as well as having a say in choosing who will adopt their child. The majority of teens choose open adoption.
- A woman who places her child for adoption has ten business days from the time she signs the consent form to change her mind and decide to parent. The adoption is final after this period of time and the birth parents can no longer regain custody after this point.
- Adoption is free to teens (or any birth parents) who decide to make an adoption plan for their child.

Abortion:

- Approximately 29% of teenagers who face an unplanned pregnancy in the U.S. choose to have an abortion
- Abortion is a legal procedure; however, in Minnesota teens under the age of 18 must either
  - a) notify both parents a minimum of 48 hours prior to the procedure (parents do not need to approve the procedure only be notified of it) or
  - b) get a judicial bypass from a judge.
- A first trimester abortion (90% of all abortions in Minnesota) costs approximately $400-$500.

Miscarriage:

- 14% of teen pregnancies end in miscarriage

Safe Place for Newborns:

- Allows for a woman who might otherwise abandon her child, to bring her unharmed newborn (up to three days old) to any hospital in Minnesota. She can do this anonymously and without any fear of being prosecuted.

The following is a list of examples typically given by students in our classes.

Note: Teen parenting, open adoption and abortion should be written horizontally on the board (instead of vertically as in this example)

Teen Parenting

Pros	Cons
Get to be a parent	Too young to parent
Want to have a child with current partner	Cannot afford child
Want to care for someone	Guilt about parenting ability
Get to watch your child grow	Impacts school, work goals
Following beliefs	No social life, no sleep

Open Adoption

Pros	Cons
Not ready to parent	Hard to make adoption plan - guilt
Following beliefs	Must carry pregnancy to term
Can see child (open adoption)	Do not want someone else raising child
Adoption is free for birth mother	Others might judge my choice

Abortion

Pros	Cons
Not ready to parent	Against abortion
Safe procedure	More expensive than adoption
Privacy (others won't know about pregnancy)	Guilt
Less expensive than parenting	Must have a medical procedure
Following beliefs (that teens shouldn't be parents)	Minors need to get approval from both parents or see a judge.

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Unplanned Pregnancy Options

Lesson 1: Teen Parenting

Introduction:

The Birds & Bees Project believes that everyone has a right to choose what pregnancy option is best for them, and for some teens, that might be carrying an unplanned pregnancy to term and raising the child. In fact, this is the decision that is made by the majority of teenagers who face an unplanned pregnancy. As educators, it's important to counteract idealized images that some teens have about becoming a teenage parent by providing teens with a realistic picture of teen parenthood so that they are able to make an informed decision if the choice becomes necessary.

Before you begin:

1. Be mindful of the language that is used when discussing teen parenting, as some of your students might be pregnant, parenting, or the child of a teen parent. Additionally, many cultures have differing views on teen parenting. Use language that does not stigmatize teen parenthood but instead focuses on teen health and accurate information.

2. At the end of this lesson we have provided important information for teens who decide to parent. Different health and parenting issues exist for teen parents than for women who decide to parent later in life. Make sure to discuss these topics as they come up in conversation or at the end of the lesson so that teens who decide to parent have the information and resources they need to take control of their health. Additional parenting resources can be found in Appendix B.

i. National Campaign to Prevent Teen Pregnancy. (2004). Factsheet: How is the 34% statistic calculated? Washington, DC: Author.

ii. Henshaw S.K. (2003). U.S. Teenage Pregnancy Statistics with Comparative Statistics for Women Aged 20-24. New York: The Alan Guttmacher Institute.

iii. Minnesota Department of Health, Minnesota Center for Health Statistics. www.health.state.mn.us

iv. Medline Plus, A service of the U.S. National Library of Medicine and the National Institutes of Health (2006). Adolescent Pregnancy. Retrieved September 2006 from http://www.nlm.nih.gov/medlineplus/ency/article/001516.htm

v. Adapted from National Standards, QTN Minnesota Benchmarks, and Sample Activities in Health Education: Kindergarten through Grade 10. Quality Teaching Network in Health Education and Physical Education, in cooperation with the Minnesota Department of Education. (2006).

vi. Adapted from the Guidelines for Comprehensive Sexuality Education: Kindergarten-12th Grade, Third Edition. (2004). Sexuality Information and Education Council of the United States. Available online at: www.SIECUS.org

Fast Facts:

1. 34% of young women become pregnant at least once before they reach the age of 20[i] -- about 820,000 unplanned teen pregnancies a year.[ii]

2. In 2004, there were 4,919 births to Minnesota females aged 15-19 and 70 births to females under the age of 15. Each day in 2004, an average of 14 teenage girls gave birth in Minnesota.[iii]

3. Teenage mothers are less likely than older mothers to complete their education, receive child support from biological fathers, and establish independence and financial security.[iv]

Goals:[v]

After completing the lessons and activities in this chapter, participants will:

1. Analyze how personal goals are influenced by changes in information, abilities, priorities, and responsibilities.

2. Analyze the short-term and long-term consequences of teen parenting.

3. Demonstrate an understanding of how the decision to parent has implications for self and others.

Key Learning Points:[vi]

- Raising children is a full-time responsibility.
- For a teenager, parenting responsibilities can interrupt schooling, employment plans, social opportunities, and family life.
- Being a teenage parent can be extremely difficult.
- Family members and community agencies can help people to be better parents or to deal with problems.

Activity: Changing Goals

Time:

60 minutes – Note: if time is a concern, have students do steps 2 through 6 as a homework assignment the evening before you teach this lesson.

Audience:

12 to 18, with an additional scenario section for students 15 to 18 *

Materials:

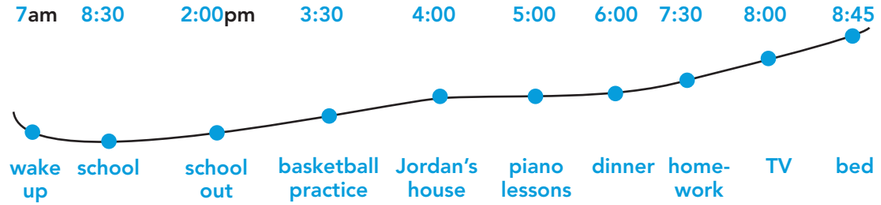
Paper
Markers

Activity:

1. Explain that the purpose of this activity is to think about how sometimes the things we do have consequences. In order to decide what we should or should not do, we need to think about how the consequences might affect us.

2. Ask students to draw a line. It may be straight, curvy or zig-zag, just not overlapping.

3. Have them list all of the things that they do in a typical school day (or what they did yesterday). Begin with the time that they woke up. Have them add additional items such as extra-curricular activities, time spent with friends, when they were at school, time doing homework, etc. Have them end with the time they go to bed, include how much time they spent doing each activity.



4. Have students repeat this activity. This time however, have them start with their date of birth. Have students write down 5 things of significance that have happened to them in their life up to this point using less than half of the space on their line (ex. sister was born, joined the soccer team, went on vacation with family, moved homes, etc.).

5. Now ask them to fill in their line with 5 to 10 future events they hope will occur through their lifetime (ex. school, career, travel, marriage/ partnership, first child, etc.)

6. Ask students to spend a couple more minutes thinking about what they need in order to achieve the goals they have written down. Ask them to write down some of these things for one or two of their goals, for example – to go to college, they would need to graduate from high school and to do that they need good grades, so they need to go to class and turn in their homework, etc.

7. Have the teens split up into 4 or 5 groups (try to have mix-gender groups if possible). Have the students focus only on their typical day timelines. Tell the students tha for the purpose of this activity, they just found out they or their partner is pregnant and that they have decided to parent the child.

8. Either pass out the "Important information for teens that are pregnant or parenting" info page (see page 116) to each group, or go over them as a class. Ask each group to take 10 minutes to consider how being pregnant or being the partner of someone who is pregnant would affect their daily routines. Ask them to consider:
   a. Are there activities in a typical day that would be impossible or would dramatically change if they were pregnant or the partner of someone who is pregnant?
   b. Is one partner more affected by the pregnancy than the other? In what ways can the male partners provide support to his partner during the pregnancy? What are some responsibilities that teen fathers could take on during the pregnancy to prepare for the child? How might preparing for the child impact their daily lives?

9. As a class, have them come back together and share their thoughts. Help your students to detect physical limitations as well as time and financial restrictions on both partners.

10. Next, have students consider the implications of becoming a parent. Have them begin by discussing how their daily routines would change if they had to take care of a child. Then have the students shift to their long-term goals timeline. How would having a child affect their education? Other aspects of their future? What kinds of financial responsibilities come with being a parent? Pass out and talk to your students about the information found in the handout, "Important Information about Parenting" (on page 118).

11. *For students 15 to 18, pass out one of the five scenarios on page 114. Tell the class that the scenarios they are about to read are examples of some typical parenting problems. Have the students spend 5 to 10 minutes considering how they would handle this problem. After the groups have discussed their dilemmas, ask them to present their dilemma and how they decided to solve it with the others in the class.
   a. Did you assume that the parent was male or female?
   b. Were there differences in the ways the males and females in your group solved the problems?
   c. In what ways might the solutions have been different if the parents were older and/or had more financial resources?
   d. What did you learn about parenting?
   e. When you were considering how your daily or lifetime timelines might change, did you consider typical parenting scenarios such as these? After practicing these scenarios would you have additional changes to make to your timelines?

12. Close the discussion with the following questions (note: the questions may be used as a reflection homework assignment rather than in-class discussion):
   a. How does having a baby affect a teen? His or her daily life? Plans for the future?
   b. What does it cost to have and raise a baby? A toddler? A child? A teen?
   c. When do your parenting responsibilities end?
   d. What do teens have to gain by choosing to wait to have a baby?
   e. What is a good age to become a parent? Did you pick that age?
   f. Do you now feel more (or less) prepared to be a parent today? In the future?
   g. Have any of your ideas about teen pregnancy changed as a result of working on this lesson. Knowing what you know now, would you be more careful to prevent a pregnancy from occurring?

Scenarios:

1. You have a two-year-old son whom your parent(s) cares for during the day so that you can go to school. On the morning of your SATs, your parent(s) calls to tell you that they cannot care for your son because they have to care for an aging relative who lives in a nursing home where children are not allowed.

2. On the night of your senior prom, you have arranged to leave your 18-month-old daughter at your sister's house overnight. Your sister has two kids and you've shared baby-sitting a great deal. This is the first time you have really gone out someplace special since the baby was born, and you really like your date. Just before your date is due to arrive, you realize that your baby is sick. She's running a high fever and is very cranky and fussy and could have a contagious illness.

3. You are the mother of a small infant whom you are breast-feeding. You want to provide the best nutrition for your baby, so you plan to nurse as long as you can. You have an interview today for a job that starts two months from now. You must travel an hour in each direction to get to the interview. The interview itself could take an hour or more. Your baby needs to nurse every two to three hours.

4. You have a newborn baby who has colic. She cries constantly for three or four hours every evening, and she needs to be held, rocked, and walked. You feel as though you are going to lose your mind. You just want her to stop. You are exhausted and feel like a terrible parent because you cannot stop her crying. You are frantic and panicked.

5. You have worked every day after school to help pay for your six month-old baby's food, diapers, clothes, and childcare. You live at home, and your parents help you care for him, but they don't have much time or money to give to you and your son. Yesterday you accidentally spilled bleach all over your work uniform, and you have to buy a new one. If you don't wear a proper uniform, you will get fired. You don't have enough money to buy both the uniform and everything you need for the baby.

Important information for teens that are pregnant

Prenatal Care:

Pregnant teens are least likely of all maternal age groups to get early and regular prenatal care. Prenatal care is the medical and physical treatment that women receive during a pregnancy – including ultrasounds, doctor's exams, healthy diet, exercise, sufficient sleep, and vitamins. Over 33% of teenage mothers receive inadequate prenatal care[vii]. The results of inadequate prenatal care can include an increased likelihood of infant mortality, low birth weight, premature birth, and health complications for mother and child. It is crucial for pregnant women to visit their obstetrician regularly throughout their pregnancy to ensure adequate prenatal care.

A typical prenatal care schedule for a low-risk woman with a normally progressing pregnancy is:

- Weeks 4 to 28: 1 visit per month (every 4 weeks)
- Weeks 28 to 36: 2 visits per month (every 2 to 3 weeks)
- Weeks 36 to birth: 1 visit per week

A woman with a chronic medical condition or a "high-risk" pregnancy may have to see her health care provider more often.

Pregnancy Discomforts:

Even healthy pregnancies include other physical discomforts such as constipation, mood swings, swelling and breast tenderness. Additionally, many pregnant women experience morning sickness, or nausea and vomiting, and a diminished appetite. Pregnant women tire more easily, and often need to take frequent naps throughout the day.

vii. The Alan Guttmacher Institute (1999). Facts in Brief: Teen Sex and Pregnancy. Retrieved September 2006 from http://www.guttmacher.org/pubs/fb_teen_sex.pdf

Physical Restrictions During Pregnancy:

Pregnant teens need to limit or avoid some activities such as participating in certain sports and lifting heavy objects. Although exercise is encouraged during pregnancy, many activities that teens participate in, such as team sports, are restricted due to the trauma they could cause the fetus. The following activities should be AVOIDED during pregnancy: ice hockey, kickboxing, soccer, basketball, gymnastics, horseback riding, downhill skiing, vigorous racquet sports, and scuba diving. Additionally, pregnant teens should avoid overheating (including using hot tubs, saunas, and jacuzzis).

Nutrition:

Teens too often have poor eating habits, neglect to take their vitamins, and may smoke, drink alcohol and take drugs, increasing the risk that their babies will be born with health problems. Studies also show that teens are less likely than older women to be of adequate pre-pregnancy weight and/or to gain an adequate amount of weight during pregnancy (25 to 35 pounds). Low weight gain increases the risk of having a baby of low-birth weight (less than 5½ pounds).[viii]

Pregnant teens must eat a balanced and healthy diet that includes: 2-4 servings of fruit, 3 to 5 servings of vegetables, 6 to 11 servings of grains, 3 to 4 servings of proteins and 3 to 4 servings of milk products daily. Teens must limit the amount of sugar and fat in their diets. Additionally, not all foods are safe for pregnant women. Some contain high levels of chemicals that can affect a baby's development, including certain types of fish, hotdogs, luncheon meats, lightly cooked eggs and soft cheeses.

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viii. March of Dimes (2004). Quick References and Fact Sheets. Retrieved November 2006 from http://www.marchofdimes.com/professionals/14332_1159.asp

Important information about parenting

Health Risk Specific to Teen Pregnancy: A baby born to a teenage mother is more at risk of certain serious problems than a baby born to an older mother including low birthweight, toxemia (high-blood pressure), premature labor, miscarriage and death of mother or infant during childbirth. Additionally, 3 million teens are infected with a sexually transmitted infection. These include syphilis (which can cause blindness, maternal death, and death of the infant), chlamydia (which can cause blindness) and HIV (the virus which causes AIDS).[ix]

Education: Teen mothers are more likely to drop out of high school than girls who delay childbearing. Fewer than half of teenagers who have children before age 18 go on to graduate from high school.[x]

Finances: Teen mothers are more likely to live in poverty than women who delay childbearing, and over 75% of all unmarried teen mothers go on welfare within 5 years of the birth of their first child.[xi]

Can you afford a baby – even for ONE YEAR?[xii]

Diapers	$750 - $1000
Baby formula	$1400 - $2,200
Baby food	$275 - $550
Health/Safety items (wipes, lotion, washcloths, bath items)	$350 - $700
Baby clothes and shoes	$400 - $600
Furniture (crib, high chair, car seat, and stroller)	$325 - $1400
Child care (full time)	$4,000 - $10,000
Medical expenses (prenatal care, delivery, hospital)	$6,680 - $9,000
Your own apartment	$7,680 - $9,200
Utilities (basic is gas, heating fuel, electricity, and water)	$3,560 - $5,720
Your other expenses (food, clothes, transport, etc.)	$1,590 - $3,180
Total cost for baby's first year	**Basic: $26,965 - Nicer: $43,550**

Basic stuff = Hand-me-downs, sale items, etc.

Nicer stuff = New clothes, regularly priced items, etc.

Costs do not include any "extras" like toys, baby pictures, babysitters, movies, medications, birthday parties, or holiday gifts.

ix. March of Dimes (2004). Quick References and Fact Sheets. Retrieved November 2006 from http://www.marchofdimes.com/professionals/14332_1159.asp

x. The National Campaign to Prevent Teen Pregnancy. Not Just Another Single Issue: Teen Pregnancy's Link to Other Critical Social Issues. Washington, D.C., 2002.

xi. Ibid.

xii. MOAPPP (2005). Dollars and Sense Fact Sheet. Retrieved September 2006 from http://www.moappp.org/Documents/DollarsAndSense.pdf

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Child Support: All children are legally entitled to child support from their father or mother, even if the parents are not married or the father did not want the mother to carry the child to term. Child Support is a monthly payment, paid by the parent who does not have custody of the child.

Paternity: Unmarried fathers will want to sign a paternity form as soon as the child is born to acknowledge that they are the baby's father. Signing a paternity form is the first step in legally establishing your relationship. Without your signature on the paternity form, you will not be able to pursue visitation and custody rights. In fact, you may lose any and all rights to be a part of your child's life. If you choose not to sign the paternity form, a court may force you to take a blood test to prove paternity at anytime until the child is 18.

Lack of Sleep: On average, a parent sleeps 350 hours less at night over their baby's first year of life than they did the previous year.[xiii] Many parents are taken aback by how exhausted they feel during those first weeks and months. Newborns usually require constant attention – they need to eat every hour or two and have their diapers changed just about as often. Most new parents will talk about how tired they are all of the time. You will care for your child all day and all night most of the time. Your child's needs will now have to come before your own. It's important that you love and nurture your baby even when your baby is being difficult or you haven't had any sleep. It is extremely important to know how to control your reactions when you feel angry or frustrated, no matter how upset or tired you feel.

Stages of Growth: Babies won't always be babies. Within a year, your baby will be walking around. By the age of two they will be talking, by three running and by four they will be able to play catch. In five years he or she will go to kindergarten. Teens should consider how the stages of their child's life impact their own personal goals.

Support from others: Consider the support you will have from family and friends. For example, do you think that they will be able to help you when you need sleep or extra help because you or the baby is sick and you have missed too many days of work or school? Can you talk with them about your questions or needs as a parent? Will they be able to help you with childcare while you are at work or school? If you don't think you have the help you need from family and friends find out if there are other resources or people who you could connect with to help you. Early Childhood Family Education (www.1minn.net/necfe) and Minnesota Organization on Adolescent Pregnancy, Parenting, and Prevention (www. moappp.org) are great parenting resources offered in Minnesota.

xiii. Dement, W.C. and C. Vaughan. The Promise of Sleep. Delacorte Press, 1999.

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Unplanned Pregnancy Options

Lesson 2: Adoption

Introduction:

Another choice teens may consider when faced with an unplanned pregnancy is adoption. Currently, only 1% of teens experiencing an unplanned pregnancy place their children for adoption.[i] Adoption has changed significantly over the past decade. Most notably, the majority of teens now choose a form of adoption called "open adoption." This form of adoption empowers the birth mother or parents to make many of the decisions about the type of family they want for their child. Adoption agencies refer to these and other choices that teens are now able to make as an adoption plan. However, many adoption agencies still offer birth mothers the option of "confidential" adoption if it is preferable in their personal circumstances.

A confidential adoption, or closed adoption, is the traditional adoption model in which the birth parents and adoptive parents do not meet or maintain contact. This is the less common type of adoption.

An open adoption can allow varying degrees and types of contact between the birth parents and the adoptive parents. In an open adoption both sets of parents must agree on the degree of contact between the birth parents and the adopted child. Some agencies that work with open adoption allow the birth parents to choose the adoptive parents after the agency completes the initial evaluations.

In the activities below when we refer to adoption, we are referring to open adoption because this is the type of adoption that the majority of teens and women now choose.

i. Moore, K. A., Miller, B.C., Sugland, B.W., Morrison, D.R., Glei, D.A., and Blumenthal, C. (1995). Beginning too soon: adolescent sexual behavior, pregnancy, and parenthood. Executive Summary. Washington, DC: ChildTrends.

Before you begin:

1. When talking about adoption, it is important to use respectful adoption language. Using accurate terminology shows respect for the birth parents, adoptive parents, and the children. Please see handout on page 129 for a list of commonly used terms and their more appropriate counterparts. Use respectful adoption language in the classroom, encourage your students to do the same, and correct any incorrect usage of adoption terms.

2. Clarify for your students the differences between confidential and open adoption and between adoption (permanent) and foster care (temporary). Often, young people do not understand the difference between these concepts – which can create misunderstandings and perpetuate myths.

3. Remind students that adoption is a legal process and if they should ever consider adoption they should consult with an attorney and/or an adoption agency.

Fast Facts:

1. The Minnesota Department of Health has a program called the Father's Adoption Registry. This program allows an unmarried father to register his name into a database if he feels he is the father of a child and would like to parent the child or be involved in planning the adoption. After the father registers, he is notified if an adoption plan is being made for the child. Registration is free and must be completed no later than 30 days after the child's birth. For more information visit: www.health.state.mn.us or call 651-201-5740.

2. Birth parents are allowed to change their minds about the adoption, up to a certain point of the adoption process. In Minnesota, the birth parent(s) must sign a "voluntary consent" form, no sooner than 72 hours after the child's birth. The birth parents have 60 days to sign the form, if they are not ready to do so after the initial 72 hours post birth. After the voluntary consent form is signed, the birth parents have 10 working days to revoke their signatures.

3. In Minnesota, minors must get their parents' or legal guardian's consent to place their child for adoption. The majority of other states (40) do not require parental involvement.[ii]

Goals:[iii]

After completing the activities in this lesson, participants will:

- Understand how decisions regarding making an adoption plan affect the child, the birth parent/s, and the adoptive parent/s.
- Analyze how a decision to make an adoption plan is influenced by individual, family, and social values.

Key Learning Points[iv]

12-15 year olds

- Family members and community agencies can be helpful when making an adoption plan.
- Children may live with one or more parents or caregivers including biological parents, step-parents, foster parents, adoptive parents, grandparents, friends, or other combinations of adults.
- Children might have a mother, a mother and a father, two mothers, two fathers, or any combination of adults who love and care for them.
- Deciding not to parent may be difficult because of societal and cultural pressures to have and raise children.*
- People may have different values and ideas about family life.*

Additional Key Learning Points for ages 15-18 year olds marked with *

ii. Guttmacher Institute (2006). State Policies in Brief: Minors' Rights as Parents. Retrieved September 2006 from http://www.guttmacher.org/statecenter/spibs/spib_MRP.pdf

iii. Adapted from National Standards, QTN Minnesota Benchmarks, and Sample Activities in Health Education: Kindergarten through Grade 10. Quality Teaching Network in Health Education and Physical Education, in cooperation with the Minnesota Department of Education. (2006).

iv. Adapted from the Guidelines for Comprehensive Sexuality Education: Kindergarten-12th Grade, Third Edition. (2004). Sexuality Information and Education Council of the United States. Available online at www.SIECUS.org

Activity 1: Building a Family

Time:

45 minutes

Audience:

ages 12-15

Materials:

Have enough of the following items for each member of your class:
paper, markers, glue sticks, magazines, scissors

1. Ask students to brainstorm what makes a family. List ideas on a board or large piece of paper.

2. Once a list has been created, ask students what adoption is, explore their ideas – dispelling myths. Be sure to explain the different types of adoption and talk about the reasons that some people choose to make an adoption plan for their child instead of choosing to parent. (Refer to the parenting activity if students have difficulty brainstorming reasons someone might make an adoption plan. Additional Adoption Resources found in Appendix B).

3. Once the students have a basic understanding of what adoption is, have them work in small groups using magazines to "build family" collages. Have the groups use scissors, magazines, and glue sticks to put together their idea of a family as it pertains to adoption. When making their collages have the students consider:
   - What makes a family a family?
   - Are their different types of families? What do different family types look like?

4. Once the groups have completed their collages, ask them to share their work with the class.

5. Ask groups what the collages have in common, as well as what is different about them. Use this discussion as an opportunity to talk about different types of families (children being raised by biological parents, adoptive parents, male or female single parent, same-sex parents, extended family members as parents, foster parents, etc.)

6. Remind students that choosing adoption means choosing to be part of building a family. Adoptive parents have made the choice to raise children, and believe that they have the resources, support, and ability to be parents.

7. Answer any remaining questions students may have about adoption or families and finish the discussion by asking the students who they could talk to if they were pregnant and wanted to consider making an adoption plan? (Answer: Family members, community agencies like Pro-Choice Resources, clergy, their local adoption agency, etc.)

Activity 2: License to Parent

Time:

30-55 minutes

Audience:

15-18 years old

Materials:

Paper
Markers

1. Explain that the purpose of this activity is to think about what qualities or characteristics people need to have to raise children.

2. As a class, have students briefly brainstorm all of the responsibilities that parents have. Have students think both generally and specifically. Make a list of these responsibilities on the board/paper.

3. Once a list of 8-10 responsibilities has been identified, ask students to spend five minutes or so writing down the qualities that they think parents should have. Tell them to think about the grown-ups that they know, and the qualities that those people have that they think are important, valuable, or meaningful.

4. Ask for volunteers to share some of the qualities that they came up with.

5. Encourage students to brainstorm additional qualities as a class and have a volunteer write them on the board/paper.

6. Explain to students that the qualities one needs to parent are important in ensuring that one has the skills, resources, and support they need to fulfill the responsibilities of parenting.

7. Tell students that they are going to be writing up job descriptions for the ideal parent. Have students get into small groups, pass out large pieces of paper and markers and list the following categories and questions on the board:

Job Description for Parents

Responsibilities:
What are some of the things that parents have to do? What responsibilities are required? Are some desired but negotiable?

Time Requirements:
How much time is required for the job? Are there certain circumstances that require more time? Less time? Is there a minimum time commitment one can have to parent?

Qualifications:
What qualifications are required? Which ones are desired? Do they change over time, as the child grows? Think creatively!

Benefits:
What are the benefits of parenting? Which benefits are obvious? Less obvious?

Compensation:
How will the parent be compensated or paid? Will the level of compensation change over time? Will they be compensated using traditional means, or are parents compensated using different types of "currency"?

8. Remind students that they are to write a complete job description, using complete sentences that might be posted in a place where people go to look for jobs. Encourage them to be creative.

9. Once they have had some time to come up with their descriptions, ask the groups to share their descriptions.

10. Now, tell them that for the purposes of this exercise, they are experiencing an unplanned pregnancy and together with their partner they have decided to place the child for adoption.

11. Take some time to go over some basic information about adoption, such as what it is, the difference between "open" and "closed" adoption, and adoption laws in Minnesota.

12. Review the handout describing appropriate and inappropriate language to use when referencing the processes and people involved in making an adoption plan with your students. Ask the students to edit their parent job descriptions as if they were searching for a parent to raise their child using appropriate adoption language.

13. If Internet access is available, consider having students read some of the parent profiles on an adoption website. Have the students decide who they might pick to parent their child and why.

14. Remind students that parenting is a very diffucult job, and not everyone has the resources, support, or ability to parent the way they would like. Similar to answering a job description and being interviewed for a job, adoptive parents have gone through home studies and extensive background checks before they can be presented to potential birth parents.

15. Close the discussion with the following questions:
    a. Why do you think so few teens decide to place their children for adoption?
    b. Do you think there are social or cultural pressures for teens to parent instead of placing their child for adoption? If so, explain?

Using appropriate language to talk about adoption[v]

Appropriate	Less-Appropriate
Birth parent	Real parent, natural parent
Birth child	Own child, real child, natural child
My child	Adopted child, own child
Person/Individual who was adopted	Adoptee
Born to unmarried parents	Illegitimate
Terminate parental rights	Give Up
Make an adoption plan, choose adoption	Give away, put up for adoption
To parent	To keep
Child in need of a family	Adoptable child, available child
Court termination	Child taken away
Child who has special needs	Handicapped child, hard to place
Was adopted	Is adopted
Choosing an adoption plan	Giving away your child
Finding a family to parent your child	Putting your child up for adoption
Deciding to parent the child	Keeping your baby
Confidential adoption	Closed adoption
Making contact with/meeting	Reunion
Parent	Adoptive parent
Child in need of adoption	An unwanted child

v. National Council for Adoption (2005). Correct Adoption Terminology. Retrieved September 2006 from http://www.ncfa-usa.org/pub_CorrectAdoptionTerm.htm

THE BIRDS & BEES PROJECT

Unplanned Pregnancy Options

Lesson 3 – Abortion

Introduction:

The third option that a teen can choose when faced with an unplanned pregnancy is abortion. According to SIECUS guidelines, students ages 9 and up should begin learning about abortion, including its safety, barriers to access and legality[i]. Additionally, as educators it is important to help young people sort through their values and beliefs by providing medically-accurate information and dispelling myths. The following lessons will help you to do just this. Additionally, we have provided information about the abortion procedure, a typical clinic experience, issues of access and safety as well as answers to some of the most frequently asked questions.

Before you begin:

1. Acknowledge that each student will probably have a different opinion on the issue. Take a few minutes before you begin the lesson to talk with your students about the controversial nature of this topic. Make sure that they, too, realize that not everyone is going to agree on a topic like abortion and that is OK. Remind students that having different views and opinions on this issue is normal, but any disrespectful comments will not be tolerated. You may find it helpful to review the class ground rules.

2. Give a brief overview of abortion, based on the guidelines on pages 133-142, before beginning the activities.

3. For educators teaching youth ages 15 and up, we recommend going over the abortion procedure with your students. This can help dispel myths as well as put the focus of abortion on health rather than political debate. Briefly review the first stages of pregnancy including: defining zygote, blastocyst, embryo and fetus as well as the process of development starting from ejaculation and ending with the blastocyst implanting into the uterine wall. Anatomy resources for reviewing this topic can be found in Appendix B.

i. Guidelines for Comprehensive Sexuality Education: K-12th Grade, Third Edition. (2004). Sexuality Information and Education Council of the United States. Available online at: www.SIECUS.org

Fast Facts:

1. "Half of all pregnancies to American women are unintended; 4 in 10 of these end in abortion."[ii]

2. 13,362 abortions were performed in Minnesota in 2005, 1,854 of which, or 14%, were performed on teens ages 19 and under.[iii]

3. Minnesota teens under the age of 18 must notify both parents 48 hours prior to having an abortion or go to court to request a judicial bypass.

Goals:[iv]

After completing the lesson and activities, participants will:

1. Describe the influence of social beliefs on health behaviors.

2. Distinguish between factual and inaccurate information about abortion and discuss where and how to access factual information.

3. Analyze information and opinions about abortion.*

4. Evaluate the effect of media on personal, family, and community health and opinions.*

5. Express information and opinions about abortion.*

* additional learning points for ages 15 to 18

ii. Guttmacher Institute. (2006). An Overview of Abortion in the United States. Retrieved September 2006 from http://www.guttmacher.org/media/presskits/2005/06/28/abortionoverview.html

iii. Center for Health Statistics: MN Department of Health. (2006). Induced Abortions in MN January - December 2005: Report to the Legislature. Retrieved September 2006 from http://www.health.state.mn.us/divs/chs/abrpt/2005abrpt.pdf

iv. Adapted from National Standards, QTN Minnesota Benchmarks, and Sample Activities in Health Education: Kindergarten through Grade 10. Quality Teaching Network in Health Education and Physical Education, in cooperation with the Minnesota Department of Education. (2006).

Key Learning Points:[v]

- The right of a woman to have a legal abortion is guaranteed by the United States Supreme Court, although there are restrictions in most states.
- State laws vary on teenagers' rights to obtain an abortion. In Minnesota, minors must notify their parents, or obtain a judges' permission before having an abortion.
- Having a legal abortion will not interfere with a woman's ability to become pregnant or give birth in the future.
- Emergency Contraception (EC or the "Morning After Pill") is not a method of abortion.
- Women have the legal right to make the final decision about whether or not to choose abortion.*
- The right of women to have legal abortions is being challenged in a variety of ways in the United States.*

* additional learning points for ages 15 to 18

v. Adapted from the Guidelines for Comprehensive Sexuality Education: K-12th Grade, Third Edition. (2004). Sexuality Information and Education Council of the United States. Available online at: www.SIECUS.org

An Educator's overview of Abortion

The following review is for use of educators.

Suggested information to provide in abortion overview to students ages 12 to 15:

1. Provide students basic information on pregnancy trimesters.

2. Discuss when the majority of abortions are completed (first trimester).

3. Differentiate for students the difference between surgical and medical abortion without describing the procedure in detail.

Suggested information to provide in abortion overview to students ages 15 to 18:

1. Provide students basic information on pregnancy trimesters.

2. Provide information on the percentage of abortions completed in each trimester.

3. Provide a detailed description of first trimester surgical and medical abortion. It can be extremely helpful to use a pelvic model or picture of the female reproductive system when describing the procedure to your students.

4. Answer questions students have about second and third trimester abortions.

5. Explain that third trimester abortions, and many second trimester abortions, are performed because of life or health of the pregnant woman is in danger or due to problems concerning the health of the fetus. Most third trimester abortions are planned pregnancies.

6. Clarify that many pro-life or anti-choice groups use images of third-trimester abortions to try to convince people and legislators to place limits on all forms of abortion.

7. Go over the different barriers to accessing abortion in the U.S.

Medical Protocol for Abortion:

All legal abortion procedures are subject to the same medical protocol as any common surgical procedure and in some states additional protocols apply (such as Minnesota's 24-waiting period). A patient must be informed of the risks and benefits of the surgery and her options regarding the surgery. In addition, most abortion providers offer unplanned pregnancy options counseling for their patients. The counseling is designed to help the patient explore her feelings about her unintended pregnancy and the option she has chosen. Often, if a patient seems conflicted over her decision to have an abortion, the clinic staff will ask her to take some additional time to examine her choice further and reschedule her abortion for a later date (if after this time she still feels it is the best choice for her).

In addition to offering patients over-the-counter pain medication such as ibuprofen, abortion providers may offer patients the option of a mild sedative, such as Valium, during the abortion procedure. The use of a mild sedative helps many women relax during the procedure and may help reduce cramping. Some clinics offer a stronger sedative for second-trimester abortions. Patients should ask their providers about the risks and benefits associated with available sedation.

Patients seeking abortions should expect the clinic staff to provide them with information about safety, risks, benefits, birth control, and counseling (if needed) and birth control.

Abortion by Trimester:

When discussing trimesters, it is helpful to draw a line on the board indicating the length of a pregnancy and the length of each trimester (see example below):

Point out to your students that 90% of abortions happen in the first trimester.[vi] In fact, 80% occur in the first 10 weeks of pregnancy (highlight the first 10 weeks on the board for your students as shown above).[vii] Only three third-trimester abortions occurred in Minnesota during 2005.[viii]

First-Trimester Abortion:

(Occurs in the beginning of pregnancy to 12 weeks and 6 days)
There are two types of abortion that women can choose from if having an abortion in the first trimester. The first and most common type is:

Surgical Abortion or Vacuum Aspiration

Procedure:

Surgical abortion is typically performed in a clinic or doctor's office, and usually takes between 5 and 10 minutes to complete. First, the physician performs a pelvic exam to determine the size and shape of the uterus. With the patient positioned as for a pap smear, the physician then inserts a speculum (an instrument used to open the vagina for medical examination), which remains in place during the abortion. The vagina is then cleansed, and injections of local anesthetic are applied to the cervix (opening of the uterus). Next, the cervix is opened by inserting and withdrawing a series of dilators. The cervix must be opened enough to admit a thin plastic tube (called a cannula), which is connected to a vacuum aspirator machine. The vacuum aspirator machine is then used to

vi. Guttmacher Institute (2006). An Overview of Abortion in the United States. Retrieved September 2006 from http://www.guttmacher.org/media/presskits/2005/06/28/abortionoverview.html

vii. Guttmacher Institute. (2006). In Brief: Facts on Induced Abortions in the United States. Retrieved September 2006. http://www.guttmacher.org/pubs/fb_induced_abortion.html

viii. Center for Health Statistics: MN Department of Health. (2006). Induced Abortions in MN January - December 2005: Report to the Legislature. Retrieved September 2006 from http://www.health.state.mn.us/divs/chs/abrpt/2005abrpt.pdf

remove tissue from the uterus. After a minute or so of suction, the doctor checks the uterus with a small spoon-shaped instrument, called a curette, to make certain all tissue has been removed. The procedure ends with another brief period of vacuum aspiration. Five to ten minutes will have passed since the start of the procedure.

What percentage of women choose surgical abortion?: 85% of all first trimester abortions in the first 8 weeks are surgical abortions.

How does it feel?: Most women say they feel pain similar to strong menstrual cramps. For others, it is more uncomfortable. See more information above about pain medication and management.

After care: After the procedure the patient will rest in a recovery room for about 30 minutes. The patient will receive written after-care instructions and a 24-hour emergency phone number. The patient may also want to relax for the rest of the day. The patient can usually return to work or school the next day, but should avoid heavy lifting and strenuous exercise for one week.

Success rates: Virtually 100% effective

Cost: $450 - $600

The second type of abortion that women and teens may choose during the first 8 weeks of their pregnancy is:

Medical Abortion

Procedure:
Medication abortion ends a pregnancy with medicine and usually without surgery. There are three steps: first, the clinician will give the patient a dose of mifepristone in tablet form. Mifepristone blocks the hormone progesterone. Without progesterone, the growth of the pregnancy stops, the lining of the uterus breaks down, ending pregnancy in the uterus, and causing vaginal bleeding. The next day, at home, the patient will take another medication called Misoprostol in tablet form. This causes the uterus to contract and empty by means of vaginal bleeding, which can last up to several hours. Third, the patient will return to their clinician for a follow-up appointment to make sure the abortion is complete.

What percentage of women choose medical abortion? In Minnesota, 15% of all women having abortions in the first 8 weeks (when medical abortion is an option) choose medical abortions.

How does it feel? Most women compare medical abortion to an early miscarriage. The patient may bleed as if having a heavy period, feeling strong cramps, temporary abdominal pain and some women report feeling uncomfortably warm and having fever or chills. Nausea, vomiting, diarrhea and dizziness are also sometimes reported. Over-the-counter medicines can reduce symptoms.

After care: The patient will receive written after-care instructions and a 24-hour emergency phone number on the day the patient takes the first medication. On the day the patient takes the misoprostol, or whenever the bleeding starts, the patient may want to stay at home and relax for the rest of the day. The patient can usually return to work or other normal activities in the next two to three days.

Success Rates: 90 to 97%. Women who do not pass the fetal tissue will need to go through vacuum aspiration during their check-up visit. Check-up visits are particularly important when having a medical abortion because it is not as effective as a surgical abortion in ending a pregnancy. Check-ups should be scheduled for one to two weeks after the medical abortion and should include an ultrasound.

Cost: $400 - $500

Medication Abortion	Vacuum Aspiration
available during first 56 days (8 weeks) of the first trimester	available throughout first trimester
process can be lengthy, sometimes taking more than 1 day	process usually takes 3-5 hours, actual procedure takes 5 to 10 minutes
much of the process can take place in the privacy of woman's home	process takes place in a medical office with a doctor and medical staff present to assist the patient through the process
although it is still an abortion, many women feel it is more "natural," like a miscarriage	minor same-day surgery without incision
woman may feel more in control	woman may feel clinician is more in control
effective 90 to 97% of the time	nearly 100% effective
if it is not effective, vacuum aspiration must be done	vacuum aspiration will be done again in the extremely rare circumstance it is not effective the first time

Second-Trimester Abortion

(13 to 24 weeks – elective second trimester abortions in Minnesota are only performed up to 21 weeks and 6 days. Between 22 and 24 weeks, abortions are only performed in Minnesota to save the women's health or life or in cases of severe fetal abnormality).

Procedure:

The most common method of abortion used in the second trimester of pregnancy is Dilation and Evacuation (D&E). The procedure is typically performed in a clinic or doctor's office and usually takes 10 to 30 minutes to complete. A second-trimester abortion carries more risk of complications than a first-trimester abortion, but it is still very safe. The D&E procedure for abortion between 13 and 16 weeks are typically completed in one day. Procedures 16 weeks and beyond typically require two separate appointments, within 24 hours. At the first appointment, the woman undergoes an ultrasound or pelvic exam to confirm the length of her pregnancy. The physician then inserts soft dilators into her cervical opening to enable the cervix to dilate gradually. The type and length of dilation will depend on the length of the pregnancy. Dilation takes several hours or more, but most women may safely return home with the dilators in place. Within 24 hours after insertion of the dilators, the patient returns to the clinic for the abortion procedure. First, the dilators are removed from the cervix, and the physician performs the vacuum-aspiration method described earlier. Next, the physician will use forceps to remove any fetal tissue that did not pass through the suction tube. The physician then checks the walls of the uterus with a curette to ensure that all fetal tissue has been removed.

After care: As with a first-trimester abortion, the patient remains at the clinic for observation but for a slightly longer length of time (45 minutes to an hour). Within 2 weeks, a post-operative exam should be performed.

Cost: $600 - $2000. The earlier the procedure is performed, the less expensive it is.

Third-Trimester Abortion

(abortions 25 weeks+)

Third-trimester abortions are quite rare in the United States; in fact only three were performed in Minnesota during 2005. Third-trimester abortions in the U.S. are performed to preserve the life or health of the pregnant woman and, in some states, if there is a severe fetal anomaly. Women who obtain third-trimester abortions are treated in a hospital or specialized surgical center, often under dire medical circumstances. Many of these women must travel across the country for a provider specifically trained in third-trimester abortions.

The type of procedure used for a third-trimester abortion varies depending on the circumstances surrounding the need for the abortion. The most common methods include induced labor and removal of the fetus with surgical instruments. Two follow-up exams are recommended one week after the procedure and, again, four weeks later.

In the majority of third-trimester abortion cases, the pregnancy was wanted by the woman. Because of the medical and emotional stresses associated with third-trimester abortions, counseling is often recommended and/or provided before and after the procedure.

Cost: $2000 and above

Note: Your students may ask about partial-birth abortion. This is a political term created by groups opposed to abortion. This is not a medical term and thus there is no medical procedure associated with the term.

Access to Abortion in the United States

Many women in the United States face barriers to exercising their right to obtain a safe and legal abortion. Barriers to reproductive health services disproportionately affect low income women, women living in rural areas, and teens. In many cases, barriers to reproductive services result in an increase in the number of second trimester abortions. In fewer cases, barriers result in women self-inducing or seeking unsafe abortions.

Shortage of providers:

Currently, 87% of all counties in the United States have no known abortion provider.[ix] Many women in rural areas have to travel over 500 miles to obtain a first-trimester abortion. The shortage of abortion providers is the result of several factors, including: harassment and violence directed towards physicians, myths about becoming an abortion provider and lack of training in abortion for medical students (only 46% of OBGYN residency programs offer training in abortion services).[x]

Funding:

In many states, low income women who rely on Medical Assistance (MA) or Medicaid programs for their health care must pay for abortions on their own. Although these MA programs routinely cover all of the costs incurred for standard medical procedures, including prenatal care and childbirth, coverage for abortion has been banned. MA in MN, however, does cover the cost of an abortion. This state-by-state policy often forces low income women to delay or forego abortion as an option for an unintended pregnancy. Additionally, coming up with $450 or more for an abortion can be costly for anyone living on a limited budget, including teens.

In Minnesota, the Hersey Abortion Assistance Fund can provide teens a grant for a portion of the abortion cost if they want to choose abortion but cannot afford it. For more information about funding, teens can call Pro-Choice Resources at 612-825-2000 or visit www.prochoiceresources.org

ix. Finer, L.B. and Henshaw, S.K. (2003). Abortion incidence and services in the United States in 2000. Perspectives on Sexual and Reproductive Health, 35(1):6–15.

x. Almeling R, Tews L, and Dudley S. Abortion Training in U.S. Obstetrics and Gynecology Residency Programs, 1998. Family Planning Perspectives, 2000,32(6): 268-271, 320.

Mandatory waiting periods:

In 1992, the Supreme Court, in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, upheld the rights of states to institute mandatory 24-hour waiting periods for abortion services, which involves talking to a physician to receive state-mandated information. Since then several states have imposed mandatory waiting periods for women seeking abortions. In many states, a 24-hour waiting period may mean repeated trips to the clinic (once for counseling and consent for the abortion, and one or two more times for the actual procedure), additional travel time and expense, and the potential delay of the abortion from the first trimester to the second trimester. In Minnesota, the 24-hour waiting period can be fulfilled by talking to the doctor on the phone; however, not all clinics offer this option.

Mandatory parental involvement:

As of 2006, teens in 35 states face mandatory parental involvement laws when obtaining an abortion (44 states have enacted laws, 9 state courts have found them unconstitutional and thus unenforceable). Parental involvement laws are commonly called "parental notification" or "parental consent." Parental notification* laws require a minor to notify one or both of her biological parents prior to an abortion. Parental consent laws require a minor to gain the consent of one or both parents before she can have an abortion. In most states that have a mandatory parental involvement law, a teen can bypass the involvement of her parents by going to court and obtaining permission from a judge*. Advocates for mandatory parental involvement claim that the intent of these laws is to foster parent child communication. In reality, 6 in 10 teens choose to involve one parent in their decision, regardless of the law. Many teens that choose not to involve their parents do so out of fear of their parents' anger and abuse. The American Academy of Pediatrics found that mandatory parental involvement laws "increase the risk of harm to the adolescent by delaying access to appropriate medical care."[xi]

* see page 147 for laws that apply in Minnesota.

xi. American Academy of Pediatrics. (1996). The Adolescent's Right to Confidential Care When Considering Abortion. Retrieved September 2006 from http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;97/5/746

Activity 1: Fact or Myth?

Time:

30 minutes

Audience:

12-18 year olds

Materials:

"Fact," "Myth," and "abortion statement" cards (which can be made using the blue text on pages 144-148)– educators need to prepare these cards prior to the beginning of the activity.

Tape

Activity:

1. Tape up "fact" and "myth" cards anywhere in the classroom - making sure there is plenty of room for students to tape up "abortion statement" cards underneath them.

2. Hand out "abortion statement" cards to students. Tell them to read what is on their card and decide whether it is a fact or myth about abortion. Once they have decided, have them get up and place their card under the appropriate "fact" or "myth" card.

3. Once the students are all seated again, start with either "fact" or "myth" and one by one, read each "abortion statement" card out loud to the class. Ask if it was placed under the correct category and why or why not. Take this opportunity to dispel any myths and clarify misperceptions about the abortion topics on the cards.

4. Conclude by having your students answer the following discussion questions
   a. What influences the perpetuation of these myths about abortion?
   b. Where can you go to get medically accurate information about health topics such as abortion?
   c. What can you do to help promote accurate reproductive health information to your family, friends and community?

Abortion Facts and Myths

1. **Abortion causes depression.** **Myth**
   Often anti-abortion groups try to portray abortion as a public health problem by stating that women who have abortions suffer from what they call "post-abortion trauma syndrome." According to the American Psychological Association (APA), there is no scientific evidence for the so-called "post-abortion trauma syndrome". Additionally, the APA reports that the time of greatest depression and stress for women is prior to the abortion. However, some teens do report feeling guilt or sadness after an abortion. These are common feelings for teens experiencing an unplanned pregnancy, regardless of whether they choose to parent, place their child for adoption or terminate their pregnancy. Teens experiencing these feelings often find it helpful to talk with a family member, friend, or counselor.

2. **The most common feeling women and teens report experiencing after having an abortion is relief.** **Fact**
   According to the American Psychological Association, the most common feelings women report after having an abortion are relief and happiness.

3. **Abortion is a dangerous procedure.** **Myth**
   Today abortion is one of the safest medical procedures available. "Fewer than 1% of all U.S. abortion patients experience a major complication. The risk of death associated with abortion in the U.S. is less than 0.6 per 100,000 procedures, which is less than one-tenth as large as the risk associated with childbirth."[xii] Additionally, since the enactment of *Roe v. Wade* in 1973, no women or girls in Minnesota have died as a result of an abortion.

4. **Most women who have abortions will not have any difficulty becoming pregnant again.** **Fact**
   Abortion does not impact a women's ability to conceive and/or carry a pregnancy to full term. In fact, for a short period of time after having an abortion women have an increased chance of becoming pregnant because their cervix was dilated during the procedure, making it easier for sperm to enter the cervical opening.

5. **Women who go to clinics do not know what will happen during the abortion procedure.** **Myth**
   Before the procedure, patients meet with a patient advocate, nurse, or counselor who will discuss the risks and benefits of the procedure and address any questions or concerns that the patient may have. This discussion is designed to help the patient explore her feelings and options, confirm that no one is pressuring her to have an abortion and to help her understand the abortion procedure.

xii. Henshaw SK. (1999). Unintended pregnancy and abortion: a public health perspective. Clinician's Guide to Medical and Surgical Abortion, New York: Churchill Livingstone pp. 11–22.

6. **Abortions are available at any doctor's office or clinic. Myth**
   There are only nineteen physicians who perform the majority of all abortions in Minnesota, North Dakota and South Dakota. In Minnesota, abortions are only available at five clinics and one hospital in the Twin Cities metro area and one clinic in Duluth. North Dakota and South Dakota each have only one abortion clinic to serve the entire state, with no abortion providers. Physicians from Minnesota provide all abortion services in these two states. The lack of clinics and providers makes it particularly difficult for many women to access abortion services.

7. **Abortion causes breast cancer. Myth**
   According to the National Cancer Institute, of the U.S. National Institutes of Health, "Induced abortion is not associated with an increase in breast cancer risk."[xiii]

8. **Abortion is one of the most common surgical procedures in the U.S. Fact**[xiv]

9. **Inadequate finances and not being ready for the responsibility of raising a child are two of the most common reasons women cite for having an abortion. Fact**
   Most women (89%) cite multiple reasons why they feel that it is not the best time in their life for them to become a parent. The most common reasons are as follows: concern for/ responsibility to other individuals (74%); cannot afford a baby now (73%); a baby would interfere with school/ employment/ ability to care for dependents (69%); would be a single parent/ having relationship problems (48%); has completed childbearing (38%). [xv]

10. **Almost 90% of abortions are performed in the first trimester (12 weeks) of pregnancy.**[xvi] **Fact**

xiii. National Cancer Institute (2003). Summary Report: Early Reproductive Events and Breast Cancer Workshop. Retrieved September 2006 from http://www.nci.nih.gov/cancerinfo/ere-workshop-report

xiv. Physicians for Reproductive Choice and Health and the Guttmacher Institute. (2006). Retrieved September 2006 from http://www.guttmacher.org/presentations/abort_slides.pdf

xv. Ibid.

xvi. Ibid.

11. **Abortion has always been legal in the United States. Myth**
    Abortion became legal in the U.S. in 1973 as a result of a U.S. Supreme Court case decision, *Roe v. Wade*.

12. **Elective abortions are performed up to 22 weeks of pregnancy in Minnesota. Fact.**

13. **One in three American women will have an abortion by the age of 45. Fact**[xvii]

14. **In Minnesota, young women under 18 years of age must notify both of her biological parents, in writing, 48 hours before having an abortion. Fact**
    Minnesota's Parental Notification law requires that a minor notify both biological parents, in writing, that she is having an abortion, 48 hours before the procedure is to occur. However, if the minor feels that she cannot tell her parents, she may seek a "Judicial Bypass" to circumvent the Parental Notification law.

15. **Women in Minnesota must hear specific, state-scripted information about abortion from a physician at least 24-hours before the procedure. Fact**
    People opposed to abortion refer to this law as the "Women's Right to Know Act;" people who support abortion rights tend to refer to it as the "24-hour Waiting Period." The law requires any woman seeking an abortion in Minnesota to hear specific state-scripted information 24 hours prior to her abortion. This information includes: risks associated with the abortion procedure; probable gestational age of fetus at the time of the abortion; medical risks associated with carrying the pregnancy to term; that medical assistance benefits may be available if the woman decides to carry her pregnancy; that the father is liabile to pay child support.

xvii. Alan Guttmacher Institute. (2003). State Facts About Abortion. Retrieved September 2006 from http://www.guttmacher.org/pubs/sfaa.html

16. **Some doctors choose not to perform abortions because of harassment and violence committed against abortion providers by people who are against abortion.** **Fact**

17. **Minors seeking an abortion in Minnesota must receive consent of their biological parents before the procedure can be performed.** **Myth**
    While some states do require parental consent in order for a minor to have an abortion, Minnesota only requires that parents be notified.

18. **Emergency Contraception causes abortion.** **Myth**
    Emergency Contraception (EC), also known as PlanB®, when taken within 72 hours of unprotected sex, can prevent pregnancy. If EC is taken after a woman has already become pregnant, it does not harm the pregnancy.

19. **Women can take an "abortion pill" to terminate a pregnancy. This pill is called RU-486 and is only available from an abortion provider.** **Fact**
    RU-486, or the "abortion pill," was approved by the FDA in 2000 and can be taken as an alternative to a surgical abortion to terminate pregnancies of up to 56 days (or 8 weeks) gestation.

20. **The majority of religions are against abortion.** **Myth**
    Most religions allow abortion under some circumstances including: Roman Catholicism; Protestant denominations of Baptist, Disciples of Christ, Quakers, Episcopal and Presbyterian, Methodist, United Church of Christ and Unitarian, Judaism, Islam, Buddhism, Hinduism, North American Native American, Taoism and Confucianism. Additionally, many religions hold multiple beliefs on abortion within their own church. For more information about the connection between religion and abortion, see Daniel C. Maguire's article in *USA Today* at http://www.sacredchoices.org/News_Tracker/where_does_God_stand_on_abortion.htm or visit the Religious Coalition for Reproductive Choice at www.rcrc.org.

Activity 2: 1973

Time:
10 minutes

Audience:
ages 12-18, additional questions and activities for ages 15 and up noted with a *

Materials:
Chalkboard or whiteboard and a writing tool

Activity:
This activity illustrates the fact that whether or not abortion is legal, there is a need for the procedure. Making abortion legal makes it safe for the women who access these services.

1. Write "1973" on the board.

2. Explain that 1973 was the year when abortion became legal in the U.S., but that women had abortions before then.

3. Ask students to think of reasons why a woman would have an illegal abortion and write all of their responses in a column to the left of "1973".

4. Next, have students think about why women have abortions today, and list all of their responses in a column to the right of "1973".

5. Once both lists are complete, compare the lists. If the lists are not nearly identical, ask students about the answers that could go in both columns. For example, if not have enough money to raise a child is in the "after 1973" column but not in the "before 1973" column ask your students if they think there were women who had abortions before 1973 that did it because they did not have enough money to raise a child.

6. Repeat this process for all answers that could go in both columns.

7. Call attention to the fact that many of the reasons women terminated their pregnancies when abortion was illegal are the same reasons they terminate them now.

8. Communicate to the students that the reason abortion was made legal was to make it safe. Make the following points[xviii]:
   a. *Roe v. Wade* has had a dramatic impact on the health and well-being of American women. Deaths from abortion have plummeted, from around 200 per year in 1965 to less than 1 per year today. In addition, women have been able to have abortions earlier in pregnancy when the procedure is safest: the proportion of abortions obtained early in the first trimester has risen from 20% in 1970 to 80% in 2002
   b. *If we look at countries where abortion is illegal today and compare them to countries where abortion is legal, we see that there are on average 20 times more women dying in countries where abortion is illegal compared to countries where it is legal.
   c. *Making abortion illegal does not make it rare. On average, two times as many abortions are performed in countries where the procedure is illegal. It is 20 times safer to have a legal abortion at 8 weeks than to carry a pregnancy to term.

xviii. Alan Guttmacher Institute. (2000). Abortion in Women's Lives. Retrieved September 2006 http://www.guttmacher.org/pubs/2006/05/04/AiWL.pdf

9. Conclude with the following discussion questions:
   a. When you hear people talk about abortion do they typically bring up the issue of safety and reproductive health of pregnant women? If not, why not?
   b. Based on our history, do you think women will continue to have abortions if *Roe v. Wade* is overturned? Are they likely to be unsafe again if it is overturned? Is this something that you think people should pay more attention to when they are discussing abortion?

Activity 3: A Day at an Abortion Clinic

Time:

20 minutes

Audience:

15 and Up

Materials:

Teacher should make cards with one step on each card. The steps on page 153 are currently in the correct order – DO NOT INCLUDE THE NUMBER ON THE CARD.

1. Make an appointment to have an abortion.
2. Notify parents or get a judicial bypass.
3. Talk with a doctor about the abortion procedure.
4. Walk through protesters outside of the clinic.
5. Enter the clinic and be greeted by the receptionist.
6. Fill out paperwork about your health.
7. Get a general health check-up (blood and urine sample, weight and blood pressure) and have an ultrasound.
8. Review the abortion procedure and discuss feelings regarding abortion with clinic staff.
9. Sign a consent form.
10. Discuss with clinic staff birth control options available post-abortion.
11. Take pain killers and return to the waiting room.
12. Pay for the abortion and wait for name to be called.
13. Meet doctor and ask final questions you have about procedure.
14. Begin the procedure – approximately 5 to 10 minutes long.
15. Talk with the clinic staff person and/or hold her hand if desired during the procedure.
16. Rest in the recovery room for approximately 30 minutes.
17. Talk to clinic staff about how you are feeling and how to take care of yourself during your recovery.
18. Make follow-up appointment.

1. Begin activity by telling the students that many teens want to know what happens at an abortion clinic. Although each clinic or hospital may have a different feel the following cards list a typical day at a clinic for a teen getting a first-trimester abortion.

2. Have students volunteer to put the steps in order. Hand out one card to each volunteer. Once students have put the steps in order, ask the class if the order is correct. Encourage group participation in correcting the order.

3. Making the following points:
   a. Even though the abortion procedure itself only lasts approximately 5 to 10 minutes, the entire process takes approximately 4 hours.
   b. Go over Minnesota law regarding parental consent or judicial bypass for teens under the age of 18 (step 2).
   c. Go over Minnesota law regarding 24-hour waiting period (step 3).
   d. Patients are always welcome to view the ultrasound is desired (step 7).
   e. Point out to students that if clinic staff feels that the patient is not confident in her decision to abort or if during the interview they find out that someone is pressuring the patient to have an abortion she will be asked to reschedule the procedure for a later date so that she can have additional time to consider whether or not abortion is the right choice for her situation (step 8).
   f. Most abortion clinics offer other reproductive health services to their patients such as annual exams and birth control prescriptions (step 10).
   g. All women and teens who have abortions should make a follow-up appointment with the abortion provider 2 to 3 weeks after the procedure to make sure that the procedure was successful (step 18).

4. Finish the activity with the following discussion questions:
   a. Do you think steps 2 and 3 are laws that help teens have safe abortions or do you think they are designed to prevent teens from getting the healthcare they desire? Do you know of any other, less safe, medical procedures that require teens to legally talk with a physician 24 hours before the surgery?
   b. Why do you think people protest outside of abortion clinics? Do people protest other surgical procedures that are legal? Do you think it should be legal to protest outside of abortion clinics or do you think this is a form of harassment? Why do you think the protesters are not there when you leave the clinic?
   c. Why do you think abortion providers send patients home if they are not confident in their decision to have an abortion or if someone is pressuring them to have an abortion?
   d. What did you learn about abortion by doing this activity? What steps were you surprised by?

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Unplanned Pregnancy Options

Lesson 4: Making Tough Choices

Introduction:

The following two activities were designed to give your students the opportunity to use the knowledge they learned over the past three lessons when faced with real-life unplanned pregnancies situations. The Birds & Bees Project believes that teens who have had the time to reflect on all of the options and resources available to them prior to an unplanned pregnancy, will be better able to make the choice that is best for them if faced with an unplanned pregnancy. The following two activities will help your students develop their own values and improve their critical-thinking skills as well as become more compassionate toward those faced with unplanned pregnancy decisions.

Fast Facts:

1. At least 75% of parents say sexuality education should cover the topic of unplanned pregnancy – including abortion.[i]

2. Some 93% of parents whose children have taken sex education believed it was very or somewhat helpful for their child in dealing with sexual issues.[ii]

3. Adolescents need opportunities to practice and discuss realistic decision making. One strategy to accomplish this is to provide more opportunities for adolescents to engage in role-playing and group problem solving.[iii]

Before You Begin:

1. Consider bringing in young people from the community who were pregnant as teens. Invite someone who chose to have an abortion; a person who placed their baby for adoption; and someone who decided to keep and raise the baby. Your local social service agencies may provide you with some guest speakers.

Note: Using a panel or guest speakers is risky unless the guests/panelists are carefully screened and given specific questions in advance. Use only guests that you have personally seen or those recommended by a trusted source.

Goals:[iv]

After completing the lessons, participants will:

1. Comprehend how parenting, adoption, and abortion are health options that a teen must decide between when faced with an unplanned pregnancy.

2. Demonstrate the ability to practice effective interpersonal communication in discussing unplanned pregnancy options.

3. *Demonstrate the ability to locate reproductive health services in their community

Key Learning Points:[v]

- People should carefully evaluate the consequences, advantages, and disadvantages of each possible unplanned pregnancy choice before they make a decision.
- Values influence a person's most important decisions.
- Teenagers with an unintended pregnancy can talk with their parents, other family members, religious leaders, counselors, healthcare providers, or other trusted adults.
- There is no unplanned pregnancy option that is right for everyone and every situation.
- * Making a decision about an unplanned pregnancy may be difficult because of societal and cultural pressures.

* additional learning points for ages 15 to 18.

Unplanned Pregnancy Options

Activity 1: Tough Choices Scenarios

Audience:

12 and up

Time:

45 minutes

Materials:

Paper and markers

Scenario cards printed/written out prior to start of lesson.

1. Have students get into small groups of 2 to 4 students. Introduce the activity by saying that now that they have learned about all three pregnancy options they are going to discuss which option to choose for the following real-life scenarios. This exercise allows young people to express multiple perspectives on this complicated issue and apply decision-making skills to real-life situations.

2. Introduce the PLANC problem-solving model to the participants. You may find it helpful to equate the model to the PLAN ABC activity on page 24.

P – Problem, identify it
L – List all possible resources and options
A – Ask for help
N – Necessary information, collect and review it
C – Choose the best option and actualize it

3. Give each group one of the following scenarios and ask them to work out solutions using the PLANC model.

4. After 15 minutes, have the teens read their solutions out loud and explain to the class what unplanned pregnancy option they decided on for the woman or teen in their scenario as well as how they came to make their decision. Ask if the decision was unanimous or if different members of that group had different opinions.

5. After every student has read and commented on their scenario, conclude by communicating to your students that there is no right or wrong choice for everyone. Every women or teen must decide for herself which choice is appropriate in her particular circumstance.

Citation:

- Kendra is a sophomore and her boyfriend, Marcus, is a junior in high school. They have been dating for almost a year. They have sex on a regular basis and always use a condom, but she got pregnant. Kendra is pro-choice, but Marcus only believes in abortion in cases of rape, incest or to save the live of the mother. She has not yet told him that she is pregnant. Kendra has told her mom who said she would support whatever Kendra decides. What should Kendra do? Why?

- Shayla is a recent high school graduate who was just accepted to Princeton University on a full academic scholarship. Her boyfriend, Anthony, was accepted to the University of Arizona, hundreds of miles away. Shayla just found out that she is pregnant. What should she do? Why?

- Olivia is 19 years old. Darion is 20 years old. They are both students at Normandale Community College. Olivia and Darion have no help paying for college. Olivia works at Target making $8 hour full-time as well as being a full-time student. Darion works two minimum wage part-time jobs and is a full-time student. If all goes as planned, they hope to graduate from college in two years. Money is very tight and every dollar goes to pay for bills, rent, and school. Additionally, they are working, studying or attending classes 60 to 80 hours per week each. They have an unplanned pregnancy. What should they do? Why?

- Paku is 16 years old and just found out that she is pregnant. Last year, her sister got pregnant and her parents kicked her sister out of the house. She is afraid to tell her parents for fear of becoming homeless. What should Paku do? Why?

- Rosario is 32 years old, happily married, and expecting her third child. She is in her sixth month of pregnancy. During a routine ultrasound, the doctors discover that the fetus has a fatal condition. Two-thirds of the brain has formed outside the skull. Carrying the pregnancy to term would greatly risk her health and life, and the baby will most likely die or remain permanently on life support. Her doctors have recommended she have an abortion because of the risk to her life; however, Rosario has always been against abortion. What should she do? Why?

- Cassie is a single mother struggling to support her child. She finds out she is pregnant, but does not feel that she can raise two children with the resources that she has. What should she do? Why?

- Lexie is facing an unplanned pregnancy and is afraid to tell anyone about it because she lives in a very small town and word travels fast. Her parents are very strict, and their religion is against pre-marital sex and abortion. What should she do? Why?

- Fatima and Mohamed are high school students. They are sexually involved. There is an unplanned pregnancy. Fatima says she loves Mohamed and wants to get married. Mohamed says he is too young to get married or be a father. Fatima does not want to raise the child as a single parent. What should they do? Why?

- Lauren is a married woman in her thirties with 3 children. She is pregnant and has no health insurance. Lauren and her husband, Michael, cannot afford to raise another child at this time. What should they do? Why?

- Jasmine is a 10 year old girl who was raped by her uncle. She did not tell anyone about the rape. Much later her mother noticed that she was sick and gaining weight. They went to see a doctor. By that time Jasmine was in bad health and over 24 weeks pregnant. What should she do? Why?

- Bau went to a party where she was drinking alcohol and doesn't remember exactly what happened. She had never had sex before, but now she is pregnant. Her friend Ly tells her she was in a room with a guy from their chemistry class for a long time. Bau is 14 and lives with her parents. She is very nervous to tell them about the pregnancy because she wasn't supposed to be at the party in the first place. What should she do? Why?

Activity 2: What's Your Plan?

Audience:

15 and up

Time:

45 minutes

Materials:

Paper and markers

Local phone books and/or internet access

1. Divide participants into three small groups.

2. Tell each group that for the purposes of this activity they and their partner are experiencing an unplanned pregnancy

3. Have them make a list of the next steps they would take before deciding if parenting, adoption, or abortion was the best decision for themselves and their partner? Who would they talk to? What information or resources are available to them? They may use phone books or the Internet when creating their list.

4. Have the class then consider if any of these resources they listed might try to persuade teens to make one choice vs. another? (ex., Crisis Pregnancy Centers are against abortion and will try to persuade teens against having an abortion. In general, adoption agencies will avoid discussing abortion, but will not actively try to persuade teens against having one. Most abortion clinics offer full-options counseling and work with adoption agencies and parenting resource agencies where they can refer clients if they decide not to have an abortion. Agencies such as Pro-Choice Resources offer resources on parenting, adoption, and abortion and are not affiliated with an abortion clinic, adoption agency, or parenting groups).

5. Now that they put together a list – assign one option (abortion, adoption, or parenting) to each group (if you have a larger class divide the class into six groups and have two groups working on each option).

6. Have each group now put together the steps that they will need to take to actualize their decision. For example, adoption steps might include: visit a physician, begin prenatal care, visit a couple adoption agencies, decide on one and begin making an adoption plan, etc. Allow teens to use the Internet if available.

7. Discuss these plans as a class and correct any misinformation or things that may have been left out.

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Appendix A

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What should I think about before I have sex?

Respect
What values did my parents teach me about sex? Do I agree with those values?

What would happen if I engaged in behaviors disapproved of by my family, my religion or my culture?

What are my goals for the future? Will being sexually active help me reach my goals or get in the way?

Consequences
- Am I ready to go to a clinic for an exam?
- Do I feel comfortable purchasing and using condoms or other birth control?
- What would I do if I had to face an STI or a pregnancy?
- Am I being pressured emotionally or physically to have sex, or is it my decision?
- How would sex change my relationship?

Emotions

What does is mean to have sex?

Different people have different definitions of sex. There is a wide range of behaviors when you feel attracted to someone that feel comfortable even if you are not ready for sex. Anything that makes you feel aroused is sexual in nature.

Health

How do I know if I am rev?

Choosing to have sex is a big decision. When you are still in your teens, it is best to wait as long as you possibly can to have sex. Here are some things to think about:

- **Health:** Your body is still developing and sex can put you at risk for sexually transmitted infections, HIV and unplanned pregnancy.
- **Emotions:** Sex brings up lots of feelings and you need to trust that your partner will respect your feelings.
- **Values:** You need to decide if having sex right now would reflect your beliefs.
- **Negative consequences:** In a healthy mature relationship, sex can be a positive experience, but sex can also lead to pregnancy, STIs and hurt feelings.
- **Priorities:** Maybe other things are more important right now like friends, sports or school work, and you would rather not worry about sex.

If I am not ready for sex, what should I do?

There are certain steps you can take to help make your choice work for you.

- Choose friends that share your decision to wait for sex.
- Decide what your sexual limits are and discuss them with your partner.
- Help each other stick to your limits, and promise not to pressure one another.

Ready?

- Find ways to express romantic feelings without engaging in sexual intercourse, such as kissing, writing love notes or holding hands.
- Go out with other couples or groups of friends.

Or not?

- Avoid situations where things could get out of control, like making out for long periods of time without anyone else around.
- Make a Sexual Health Plan. Decide when and under what circumstances you will be ready for riskier sexual activity and learn about birth control and Sexually Transmitted Infections (STIs). It's important to make a plan before you have sex so you are prepared to make an informed and safe decision rather than a heat-of-the-moment decision.

Have a Question?

Contact **The Birds & Bees Project** at pcr@birdsandbees.org

Waiting

Who is choosing to wait to have sex?

While it may seem like everyone is having sex the truth is, they're not.

- According to the Minnesota Student Survey in 2004, only one out of five 9th graders and less than half of all high school seniors had ever had sexual intercourse. **In other words more than 50% of high school students are not having sex.**

Your Future

Why should I choose not to have sex?

- Choosing not to have sex is a conscious decision anyone can make at any time in their lives.
- A person may choose to stop having sex at any point in their lives, even if they have already been sexually active.
- Limiting the number of sexual partners you have over your lifetime greatly reduces your risk of contracting sexually transmitted infections and HIV.
- Sexual intimacy can be a very emotional experince. As a result, break-ups can be even harder if you have had sex.
- Developing a healthy, trusting relationship with another person takes time. Some relationships are just too short to take such risks.

What Other Teens Have to Say…

"Parents are generally more informed than your friends or peers. You're probably more comfortable with them than you are with your teachers. So who better to go to with your questions? If you want to know, ask! If your parent(s) start the conversation, don't let it be awkward. Listen, give feedback, and show them that you appreciate their input - even if you find it a little weird."

-Katie, 17, Highland Park High School

"If you have questions, they need to be answered about this kind of stuff; it's more serious than you think. Your friends can't give you the kind of information you need to know, your parents are your best bet."

-Tamika, 16, North High School

"Be open and start asking questions at a young age. Then when you are older and have more intensive questions to ask them, it won't be as big of a deal. Just remember too, your parents were once your age."

-Tré, 13, Anthony Middle School

"Just do it… you will feel closer to your parents afterwards and your parents will feel like they can trust you just a little bit more… because you're open with 'em."

-Jonathan, 15, South High School

If you need a little more help getting the conversation started, check out the following resources:

www.familiesaretalking.org
Click on "For Young People"

www.teenwire.com

www.moappp.org
Click on "For Teens"

www.advocatesforyouth.org
Click on "For Youth"

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Before you begin...

We know that talking to your parents or another caring adult about sex can be difficult. You may feel awkward or nervous, and may be afraid of what your parents will think. Maybe you just don't know what to say. However, after having a conversation with an adult about sex most teens say it was VERY helpful. This brochure has been created by teens for teens to use as a guide to figure out the best way to go about talking to your parents about this challenging topic.

Be Prepared

When beginning a tough conversation, it is best to be as prepared as possible. Some teens talk to a friend to see what approaches work or don't work, but it is always a good idea to decide what you want to know. The more time you spend thinking about questions, the more comfortable you will be when the conversation begins.

Who to Talk to and When to Talk

You may feel more comfortable talking to someone other than your parent – like your aunt or a friend's dad. Whomever you decide to talk to make sure to choose the right time for the conversation. Wait until your parent/other caring adult isn't distracted, because it will be a lot easier to have a conversation if you don't have to do all of the talking.

What to Say...

There is no perfect way to begin a conversation about sex. Below are a few "tried and true" options teens have used successfully:

- **To the point.** Just come right out and say it. "I have a question about something I learned in my health class."
- **Beat around the bush.** Start with a broad comment or question and follow up with some more specific questions. "Did you read that article in the paper about schools providing condoms to teens?"
- **I wonder if/how/why/what...** This gives your parent the perfect opportunity to share their opinions and advice. "I wonder how someone growing up 40 years ago would have felt about teen parenting. What did you think while growing up? Do you feel differently today?"
- **I've heard that...** Tell your parent what friends or the media have said and see what your parents know. "I heard on the news that there is a new STI vaccine, is that true?"
- Wri**te a note.** If your parent is busy, this may be a good way to get their attention. Try asking for a few minutes to talk or just make a list of your questions.

How to Say It...

So you've decided to do it. You have the perfect conversation-opener and you know what you want to find out. To make sure the rest of your conversation goes well, here are a few tips suggested by teens.

1) **Listen.** Teens say it is easiest to talk when someone is actually listening. Listen to what your parents have to say and insist that they treat you with the same respect.

2) **Don't rush it.** Yes, you may be embarrassed, but your parents probably are, too. Don't end the conversation until you are satisfied with how it went.

3) **Remain open.** Your parents may ask you some personal questions. Tell the truth, because your parent will appreciate your honesty.

4) **Ask questions.** If you don't ask, your parents can't answer.

5) **Be polite.** If you disagree with something that is said, explain why, but be respectful of your parent's opinions.

Why do I need to do this, again?

It is your parent(s) job to protect your health and safety, even when it comes to dating and sexual relationships. Your parent(s) will also be able to give you more accurate information than a friend and will respect you for the courage you had to begin a conversation. Also, if you have talked to your parents about sex, it will be easier to be open with them about issues that may come up in the future.

Have a Question?

Contact **The Birds & Bees Project** at
pcr@birdsandbees.org

What is there to talk about?

Many teens report that the easiest topic to talk about with their parents is healthy relationships. This may be a good topic for you to discuss with your parents first, or there may be another topic you are more comfortable talking about. If your first conversation is positive, it will be easier to talk about more difficult issues later.

Birth Control • Your Parent's Opinions on Sexual Issues • Abstinence
Kissing • Unplanned Pregnancy Choices: Adoption, Abortion and Parenting
Sexual Abuse • Emergency Contraception • Sexual Orientation
HPV Vaccine • Sexual Health (STIs/HIV/AIDS)• Sex

Parenting

Can I be a parent?

Only you can decide when you're ready to be a parent, and you have to weigh all the options yourself. You are making a big decision and taking on a huge responsibility.

Basics

What should I do when having a child?

When you're pregnant, see a doctor right away for help. Basics to consider are:

- Eat a balanced diet.
- Drink lots of water.
- Avoid alcohol, tobacco and drugs.
- Avoid medication without a doctor's permission.
- Get lots of rest.

Partnership

What if I don't have a partner?

You can be a single parent and still be a good parent. It can be especially difficult when you take on all responsibility for a child yourself. Having a partner can certainly help, but can add stress if they are not committed to being a good parent.

Support

How can I get child support?

You're entitled to child support from the father of the child. Minnesotans can contact the Office of Child Support Enforcement at 651.296.2542.

What services are available to me?

There are many services in Minnesota to help you be the best parent you can be. Check out the Adolescent Parent Network directory at: http://www.moappp.org/apn/search.php

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Options

What are my options?

When you become pregnant, you have three choices:

- Adoption-when you want to carry the child but don't want to parent.
- Abortion-when you're not ready to carry a child or be a parent.
- Parenting-when you want to raise a child.

Choice

What do pregnant teens choose?

56% of teens choose parenting. 29% choose abortion, 1% choose adoption and 14% miscarry.

Tough Choices

What decision is best for me?

Deciding which unplanned pregnancy option to choose can be a very tough and individual decision. Take the time to consider:

- The consequences, advantages and disadvantages of each choice.
- Who you can talk to about your decision: parents, other family members, religious leaders, counselors, healthcare providers, or other trusted adults.
- Your values and future plans.
- Unplanned pregnancy may be difficult because of societal and cultural pressures. The decision you make may be very different from the decision your closest friend would make. Don't let the opinions of others influence what you believe is the best decision for you, and don't try to influence others to make the same decision you choose.

Abortion

Why have an abortion?

Abortion is an option if you cannot or do not want to be pregnant or be a parent. There are many responsibilities to parenting which you might or might not be able to take on right now.

Disclosure

When having an abortion, do I have to tell my parents?

Minnesota law requires minors, teens under 18 years old, to notify both legal parents at least 48 hours before having an abortion.

Legal

What if I can't tell my parents?

A teen who decides not to tell her parents must receive a Judicial Bypass. To receive a bypass you must talk to a juvenile court judge about why you can't tell your parents. Your clinic will refer you to someone at juvenile court who can help you.

Waiting

How long will I have to wait?

After scheduling an abortion you have to wait at least 24 hours. You will be provided with some information by a doctor.

Safety

Are abortion procedures safe?

Yes, abortion procedures are safe. Only 2.5% have minor complications that can be handled at a doctor's office; and less than 0.5% require some additional surgical procedure. You're ten times more likely to die during childbirth than from a legal abortion.

Have a Question?

Contact **The Birds & Bees Project** at pcr@birdsandbees.org

Adoption

After deciding on adoption, can I still change my mind?

Adoption is a permanent legal arrangement, and you cannot reclaim your child after the adoption becomes permanent.

Future

Who can adopt a child?

All types of people can adopt. Also, if you choose open adoption, you will be able to make many decisions about your child's adoption plan - often including choosing your child's parents.

Rights

What rights does a minor have when placing a child for adoption?

Minors under age 18 must get parental signatures to plan an adoption for their child. Birth parents can be very involved in developing an adoption plan that is comfortable for everyone.

Involved

What can I expect from an "open adoption"?

Open adoption allows for involvement with your child. Birth parents can receive detailed information about the adoptive parents and can negotiate how much involvement they have in the child's future.

Removed

What can I expect from a "confidential adoption"?

Confidential adoption means you have no future involvement with your child. After the adoption is final, you will have no legal rights to your child or access to information about their life.

Infections

What is an STI?

STIs, Sexually Transmitted Infections, are the same thing as STDs or Sexually Transmitted Diseases. STIs are passed during sex and other close body contact. Most symptoms appear in the genital area and many can affect your entire body. All are treatable and many but not all, are curable. Untreated, all STIs can have serious health effects.

Consequences

What health problems can STIs cause?

Left untreated, STIs can:

- Cause damage to reproductive organs
- Lead to infertility in men and women
- Continue to spread through sex partners and shared needles for injection drug use, piercing or tattoos
- Cause heart disease, blindness, arthritis, brain damage or death

Acting

What should I do when I might have an STI?

Get tested immediately. Go to a doctor or a health clinic and get checked for STIs. Be honest about your sexual background and share any information that could be important.

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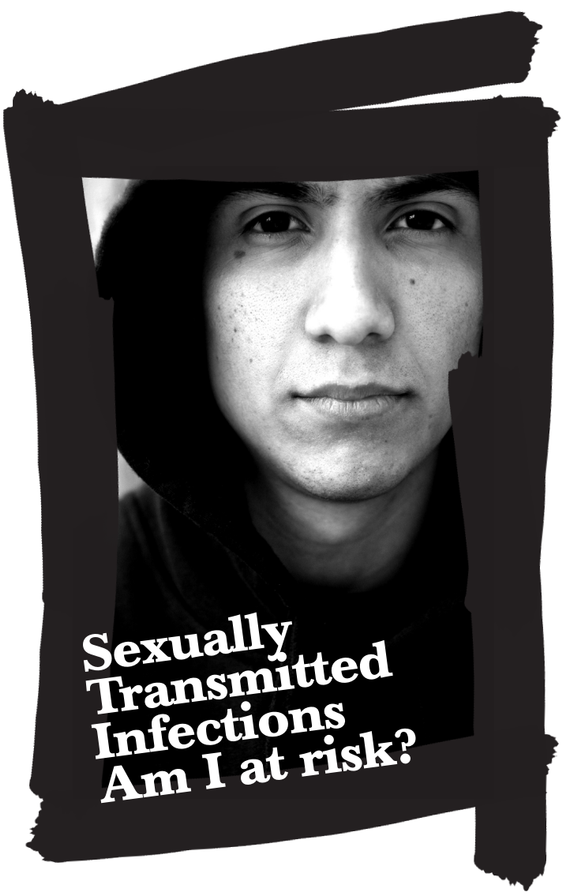

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Risks

What puts me at risk for getting a Sexually Transmitted Infection (STI)?

- Vaginal, oral or anal sex with an infected person
- Skin to skin contact, with an infected person
- Infested towels or bedding (with lice and scabies)
- Sharing infected needles for piercing, tattoos or injecting drugs, steroids or hormones

Infections

What can I do to avoid getting infected?

- Avoid being sexually active
- Have sex with only one partner who is not infected
- Talk to your partner
- Look at your partner's genitals before having sexual contact
- Use latex condoms (or polyurethane)
- Get checked for STIs by a doctor
- Know signs and symptoms of STIs
- Treat partners and avoid sex until infection is cured

Safety

What should I ask my partner?

- Past sexual partners
- Last time they were checked for STIs
- Protection and what to use
- Possible symptoms and problems
- Precautions and risks of activities

Ask

What should I ask my doctor?

- Describe your symptoms
- Give your sexual history
- Explain what you're worried about
- Point out any unusual sores, bumps or rashes
- Describe any pain, itching or redness

Symptoms

What are some general STI symptoms?

- Sores, bumps or blisters around genitals or mouth
- Burning or pain when peeing
- Need to pee often
- Itching, redness or swelling in or around your genitals
- Swelling or redness in throat
- Fever, chills and aches like having the flu

Cautions

What should a female watch for?

- Unusual vaginal discharge or smell
- Burning or itching around vagina
- Bleeding, not from period
- Pain deep inside when having sex
- Pelvic pain, different from menstrual cramps

What should a male watch for?

- Watery white discharge from penis
- Thick yellowish discharge (pus) from penis
- Any other unusual drip or discharge from penis

Get Tested

What should I do when I have no symptoms?

When you suspect that you might have contracted an STI, for any reason, you should get checked by a doctor. **Many STIs don't have noticeable symptoms,** or take time before symptoms appear. Getting tested can protect you and your partner.

Have a Question?

Contact **The Birds & Bees Project** at pcr@birdsandbees.org

Prevention

What kind of protection is most effective for preventing STIs?

Use condoms or dental dams with water-based lubricants during sex acts.

What activities should I be careful about?

Sexual contact in which vaginal fluid, semen, or menstrual blood may be shared. Also, skin to skin contact can put you at risk for herpes, crabs or warts.

Protection

What should I use for protection during oral sex?

For fellatio (mouth on a penis), condoms should be used. Other types of sex acts, such as cunnilingus (mouth on a vagina) or rimming (mouth on an anus) need a dental dam.

How do I make a dental dam?

To make a dental dam, use plastic wrap or follow these instructions with a condom:

1. Use a new condom and cut from opening to tip.
2. Spread condom open into a sheet.
3. Place side with most lubricant against skin.
4. Use a new dental dam for each oral/ anal or oral/ vaginal sex act.

How do I use a condom?

1. Remove condom from package.
2. Before sexual contact, when penis is hard, squeeze the tip of the condom to remove air.
3. Place the condom on the tip of the penis and roll it down all the way.
4. After cumming, hold the rim of the condom and withdraw while still hard.
5. Wash any areas that came in contact with bodily fluids.
6. Use a new condom before each sex act.

Where can I learn more?

Resources for Parents:

Websites:

Families are Talking
Information for teens and parents on sexuality issues in English and Spanish.
www.familiesaretalking.org
www.lafamilahabla.org

Advocates for Youth
Resources and information regarding numerous health and well-being topics, such as sexuality, body image and relationships for teens and parents.
www.advocatesforyouth.org

Books:

Beyond the Big Talk: Every Parent's Guide to Raising Sexually Healthy Teens-From Middle School and Beyond.
Haffner, Debra W. New York: Newmarket Press, 2001.

How to Talk with Teens About Love, Relationships and S-E-X: A Guide for Parents
Miron, Amy G. and Charles D. Minneapolis, MN: Free Spirit Publishing, 2002.

It's So Amazing! (ages 7 to 10) and It's Perfectly Normal (ages 10 and up).
Harris + Emberley, Candlewick Press, 2004
Illustrated sexual health books for younger audiences.

DVD:

The Talk: An Intercours on Coming of Age
For ages 12 to adult. www.youthperformanceco.com or 612-623-9180

Citations:
1. Resnick MD, et al. Protecting adolescents from harm: finding from the National Longitudinal Study on Adolescent Health. JAMA 1997; 278: 823-32. Advocates for Youth.
2. Miller KS et al. Patterns of condom use among adolescents: the impact of mother-adolescent communication. Am J Public Health 1998; 88: 1542-44.
3. Shoop DM, Davidson PM. AIDS and adolescents: the relation of parent and partner communication to adolescent condom use. J Adolescent 1994; 17: 137-48.4. J. Jaccard and P. Dittus, "Parent-Adolescent Communication about Premarital Pregnancy: Families in Society,vol 74, pp. 329-43
5. Adovcates for Youth, Parents Sex Ed Center. www.advocatesforyouth.org
6. Hacker KA et al. Listening to youth: Teen perspectives on pregnancy prevention. Adolescent Health 2000; 26:279-88.
7. MOAPPP; Communicating with Children about Sex. http://moappp.org/Documents/communications.

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Tips for Talking with Your Teen

1) **You are the Primary Sexuality Educator for Your Kids.**
They want to talk to you about sexuality and hear your values.

2) **Find "Teachable Moments"**
Talking about sex does not have to be a formal conversation. Books, TV shows and news articles can be wonderful discussion starters.

3) **Talk Early, Talk Often**
It is never too early, and it is never too much. Don't wait for your child to ask because many never will.

4) **Be "Ask-able"**
Reward questions with answers such as, "I'm glad you came to me." This will teach your children to come to you when they have other questions.

5) **Make It Normal**
Throughout your childs life, encourage openness about anatomy and body function.

6) **Use Specific and Correct Terminology**
Use a common vocabulary so you and your child can understand each other.

7) **Listen More Than You Talk**
Ask them what they want to know. Don't judge, just listen.

8) **Talk with Other Parents**
They are a great source for support and information.

9) **Know What is Taught in Your Schools**
Many schools do not teach sexual health or focus only on abstinence. You are your child's first resource.

Age-Appropriate Sexuality Education is Important at Every Age and Stage of Development.

At ages 9 to 12 most young people will:

- **Enter puberty:** a time of increased production of hormones. Skin becomes oily and might develop pimples; sweating increases and youth may have body odor and pubic hair begins to grow.
- **Masturbate:** (both males and females) and have fantasies about sex.
- **Experience body changes such as:**
  Males: genitals mature, scrotum darkens, voice deepens, sperm is produced and erections, ejaculation and wet dreams are more frequent.

  Females: genitals mature, breasts develop, ovulation and menstrual cycle begins.

At ages 13 to 17 most young people will:

- Complete puberty and the physical transition from childhood to adulthood.
- Continue to be influenced to engage in sexual behaviors by peers and the media.
- Build skills to become self-sufficient, develop mature relationships and seek increased power over their own lives.

Have a Question?

Contact The Birds & Bees Project at pcr@birdsandbees.org

Why Is It Important to Talk About Sex with My Kids?

Teens report that they would prefer to get information about sex from their parents rather than any other source.

- Young people who feel connected and supported at home develop healthy attitudes and behaviors, and are more likely than other teens to delay sexual intercourse. [1]
- When mothers discuss condom use with their teen before they become sexually active, they are three times more likely to use condoms than teens whose mothers never discussed condom use or who discussed condom usage after they became sexually active. [2]
- Teens who had previous discussions of sexuality with their parents were seven times more likely to feel able to communicate with a partner about HIV/AIDS than those who had not had such discussions with their parents. [3]

When Should I Talk About Sex?

- It is never too early, or too late, to talk with your child about sex. These conversations help lay the foundation for healthy behavior throughout a lifetime.
- Kids ask questions about sexuality at the most awkward times. Tell them you are glad they asked, give them a short answer and tell them you can talk more about it later and follow through with an age appropriate, but accurate explanation.

Where can I get these pills?

The Birth Control Pill

You can get a prescription from your clinic or if you don't have a clinic you can call:

The Minnesota Family Planning and STD Hotline 1-800-78-FACTS to find out where to get low-cost birth control in your neighborhood.

For More Information on the Web:
www.birdsandbees.org
www.plannedparenthood.org
http://www.stdhotline.state.mn.us/

Emergency Contraception

"the morning after pill" or "EC"

If you are under 18 years of age, you can get a prescription from your clinic or if you don't have a clinic you can call:

Minnesota Family Planning + STI Hotline 1-800-78-FACTS to find out where in MN you can get EC.

National Emergency Contraception Hotline1-888-NOT-2-LATE

If you are older than 18 years of age, you can buy EC over-the-counter at many pharmacies.

For More Information on the Web:
www.birdsandbees.org
www.backupyourbirthcontrol.org
www.go2planb.com

The Abortion Pill (RU486)

The abortion pill is only available through clinics that provide abortion services. For more information about abortion contact:

Pro-Choice Resources (612)825-2000 to receive:
- A referral to a local abortion provider
- Answers to your abortion questions
- Information on current abortion laws
- Financial assistance to help you pay for your procedure

For More Information on the Web:
www.birdsandbees.org
www.abortionclinic.org
www.prochoiceresources.org

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THE BIRDS & BEES PROJECT

612.821.9795 WWW.BIRDSANDBEES.ORG

What everyone should know about three little pills!

The Birth Control Pill

Prevents Pregnancy

- The pill, when taken properly, is up to 99% effective in preventing pregnancy.
- You have to get a prescription from a doctor.

The pill has been around for over 30 years and is used by millions of women worldwide. It is the most common form of birth control for American women.

The pill stops the ovary from releasing an egg so fertilization cannot occur.

The pill should be taken at the same time every day. Taking the pill at varying times or forgetting a pill decreases its effectiveness

If you do forget, take your missed pill as soon as you remember. If you miss two or more pills, you must use a back-up method of birth control, like condoms, for 7 days. Emergency Contraception can also be used if necessary.

Emergency Contraception

("the morning after pill" or "EC")

Prevents pregnancy but will not harm an existing pregnancy

- If taken up to 72 hours after unprotected sex, EC is 89% effective in preventing pregnancy.
- The sooner you take EC, the better it works.
- If you are under 18 years of age, EC is only available with a prescription.
- If you are 18 or older, EC is available over the counter (without a prescription) at many pharmacies.

EC can be used as back-up in case no birth control was used, the condom breaks or if you are sexually assaulted.

- EC pills are a higher dose of the same hormones contained in the birth control pill. EC prevents an egg from being released from the ovary and makes cervical mucus thicker so sperm can't get through.
- Two separate pills are given; one is taken right away and one is taken 12 hours later.
- EC should NOT be used as a regular form of birth control.

The Abortion Pill

Ends a pregnancy by making the body shed the pregnancy tissue

- 95% effective in terminating a pregnancy (in the rare case that it doesn't work, a surgical abortion would be required).
- Available only at an abortion clinic. "The Abortion Pill", also known as Mifeprex™, has been available in the U.S. since September of 2000. The abortion pill is considered very safe, and is the most common method of abortion in Europe where it has been used for over 10 years.

The Abortion Pill can end a pregnancy if taken within 7 weeks of your last period.

This method of abortion is a three-step process:
1. Clinic visit — After an exam, women who qualify can take the abortion pill.
2. A day later, another pill is either swallowed or inserted vaginally to complete the abortion.
3. Several days later, a second clinic exam is administered to make sure the abortion is complete.

Sample Letter 1

Dear Parent or Guardian,

This letter is to inform you that next week we will be beginning a unit on Sexuality and Reproductive Health. Your child will be receiving age-appropriate, medically accurate information on the following topics as part of this unit: communication, abstinence, contraception options, STI prevention and unplanned pregnancy options – including adoption, abortion and parenting.

We will be encouraging your child to discuss the topics we will be covering in class with you at home. Enclosed with this letter you will find a brochure entitled, "How Do I Talk To My Kids About Sex?" You may find this brochure helpful in facilitating conversations with your child about sexuality and reproductive health.

If you have any questions about the upcoming lessons, please contact me at (phone number) or (e-mail address).

Sincerely,

Health Teacher

Sample Letter 2

Dear Parent/Guardian,

This letter is to inform you that as part of our Sexuality and Reproductive Health unit, your child will be receiving age-appropriate, medically accurate information on the topic of Unplanned Pregnancy Options.
The material covered will include information about teen parenting, adoption, and abortion. Students will participate in a values clarification activity, as well as learn facts about teen pregnancy and the legal issues associated with each option.

If you do not want your child to participate in the Unplanned Pregnancy Options segment of our unit on Sexuality and Reproductive Health, please sign the bottom of this letter and have your child return it to his/her teacher no later than (date).

Enclosed with this letter you will find a brochure entitled, "How do I Talk to my Kids about Sex?" You may find this brochure helpful in facilitating a discussion with your child about sexuality and reproductive health.

If you have any questions about the upcoming lessons, please contact me at (phone number) or (e-mail address).

Sincerely,

Health Teacher

Return this slip only if you do NOT want your child to receive information on Unplanned Pregnancy Options.

I, _____, do NOT want my son/daughter _____ to participate in learning about Unplanned Pregnancy Options.

Parent/Guardian Signature: _____Date: _____

THE
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Online Resources

The Birds & Bees Project - www.birdsandbees.org

The Birds & Bees Project website is a great starting point for teens, educators and parents when looking for reproductive health information. The site contains comprehensive reproductive health information specific to Birth Control, Sexually Transmitted Infections, Pregnancy and Unplanned Pregnancy Options. The site is divided into three sections; information for teens, educators and parents. Educators are able to download our teacher's guide and all of our educational tools to use in their classroom from the site. Additionally, educators may sign up for our monthly e-digest, to stay up to date with the latest reproductive health information and news, and ask our educators questions specific to teaching reproductive health. We also have links to the websites below as well as others we deem reliable on our site.

Note: The internet resources listed below are only a small sample of what is available. To ensure you are accessing accurate health information and resources on the internet, be sure to check the source of the information. Keep in mind, that although we have organized the websites by intended audience and topic, many of the websites mentioned below can be helpful and informative for those outside of the target audience and topic area.

Communication

- **Families are Talking - www.familiesaretalking.org**
  The Families Are Talking website is a project of the Sexuality Information and Education Council of the United States (SIECUS). It provides information and resources for young people, parents and caregivers (primary audience: teens and parents).

- **Talking about Health - www.abouthealth.com/t_talking.htm**
  Family Health Productions helps young people, their peers, and families, learn to talk about the challenges kids face growing up (primary audience: teen and professionals).

- **Resource Center for Adolescent Pregnancy Prevention (ReCAPP)- www.etr.org/recapp/**
  ReCAPP provides practical tools and information to effectively reduce sexual risk-taking behaviors. Teachers and Health Educators will find up to date, evaluated programming materials to help with their work with teens (primary audience: professionals).

- **Talking with Kids about Tough Issues - www.talkingwithkids.org/**
  A national initiative by Children Now and the Kaiser Family Foundation encourages parents to talk with their children earlier and more often about though issues (primary audience: parents).

- **Shoulder to Shoulder Campaign (MN) - www.shouldertoshoulderminnesota.org**
  The Shoulder to Shoulder Campaign is a campaign for Minnesota parents of teens. They provide real advice and resources for parents of teens for how to navigate the teen years (primary audience: parents).

Reproductive & Sexual Health Resources

For Teens:

- **It's Your (Sex) Life - www.itsyoursexlife.com**
  This site is a project of the Henry J. Kaiser Family Foundation and MTV.
- **My Sistahs - www.mysistahs.org**
  Information and support on reproductive health topics, by and for young women of color.
- **Sex, etc. - www.sexetc.org**
  This site includes articles on a variety of sexuality topics. The editorial board and writers of this site are all teens.
- **Scarleteen - www.scarleteen.com**
  This site has fully staffed message boards so teens questions sex can be answered by trained volunteers and staff members almost INSTANTLY.
- **Minnesota Teen Health - www.teenhealth411.org**
  Created by Twin Cities teen clinics, this site provides information on adolescent health and services available to teens living in the Twin Cities area.
- **Teenwire - www.teenwire.org**
  A project of Planned Parenthood, this site provides information, activities, and resources for both youth and others.

For Professionals:

- **Advocates for Youth - www.advocatesforyouth.org**
  Advocates for Youth provides information, training, and support for youth-serving individuals, organizations, and youth themselves. AFY offers lesson plan ideas, current event updates, training opportunities, policy information, and a comprehensive list of evaluated programs that have been proved to reduce teenage pregnancy, STIs and sexual risk taking.

- **Sexuality Information and Education Council of the United States - www.siecus.org**
  SIECUS provides training, information and resources for educators, health professionals, parents and policy makers.

- **Allan Guttmacher Institute - www.guttmacher.org**
  Resource for reproductive health research, education, and policy analysis.

- **Centers for Disease Control and Prevention - www.cdc.gov**
  For more detailed information on STIs

- **Sexuality and Family Life Educators - www.sfle.org**
  A twin-cities (and limited greater-MN) coalition of community agencies dedicated to promoting healthy adolescent sexuality. These agencies are available to provide such services as: guest speakers, professional training, and technical assistance.

- **Emergency Contraception - www.not-2-late.com**
  This site provides accurate information about emergency contraception, available in English, Spanish, French, or Arabic.

Additional Reproductive Health Resources Specific to Unplanned Pregnancy Options

- **Pro-Choice Resources (PCR)- www.prochoiceresources.org**
  PCR is a Twin Cities non-profit that works to reduce the barriers to accessing reproductive healthcare by providing education, advocacy, financial assistance, and outreach locally and nationally. PCR provides non-biased information and referrals for all unplanned pregnancy options. Additionally, PCR runs the Hersey Abortion Assistance Fund which provides grants to teens that choose abortion but cannot afford the cost of the procedure. PCR also houses the Birds and Bees Program. PCR is not affiliated with any abortion clinic or adoption agency.

- **Planned Parenthood: Choosing Abortion - http://www.plannedparenthood.org/birth-control-pregnancy/abortion/choosing-abortion.htm**
  A resource from Planned Parenthood which answers the concerns of women and teens considering abortion, from how abortions are performed to what a woman can expect after the procedure.

- **NARAL Pro-Choice America – www.naral.org**
  This web site has a state-by-state review of abortion and reproductive rights laws.

- **Child Welfare Information Gateway - http://www.childwelfare.gov/systemwide/statistics/adoption.cfm**
  The federally funded one-stop resource for information about adoption and related issues.

- **Children's Home Society & Family Services (CHSFS) – www.chsfs.org**
  CHSFS provides decision making counseling to women and teens throughout MN who are experiencing an unplanned pregnancy. Additionally, if a woman, teen or couple decides to make an adoption plan, CHSM is an adoption agency and can work with both the birth mother/family and adoptive family to carry out the plan.

- **The Evan B. Donaldson Adoption Institute - http://www.adoptioninstitute.org/proed/procurric.html**
  A national non-profit devoted to improving adoption policy and practice. Includes an adoption resource guide for educators.

- **Minnesota Organization on Adolescent Pregnancy, Parenting, and Prevention (MOAPPP) - www.moappp.org**
  Local information, materials, research, policy analysis, and training opportunities for teens who choose to parent as well as information on teen pregnancy prevention. See: http://www.moappp.org/apn/search.php for a list of academic, childcare, health, in-home and parent education resources for young parents in Minnesota.

- **Healthy Teen Network - http://www.healthyteennetwork.org/**
  Provides education, training, information, advocacy, resources and support to professionals and organizations that work with teens, with an emphasis on teen pregnancy, pregnancy prevention, and teen parenting.

- **Early Childhood Family Education (ECFE) - www.1minn.net/2ecfe**
  ECFE provides parent-child activities, parent discussion groups, home visits, special events, book and toy library, information on community resourses and programs for non-English languange learners.

- **Safe Place for Newborns of Minnesota:** Mothers can bring their unharmed newborn baby, up to 3 days old, to any hospital in Minnesota. Authorities will not be contacted, and she does not have to identify herself. 24-hour crisis hotline - 877-440-2229. www.safeplacefornewborns.com

Minors Consent

- **Hennepin County Medical Center - http://www.hcmc.org/depts/documents/consentconfidbr.pdf**
  View or print a copy of the Consent and Confidentiality brochure (Legal Guidelines for Providing Medical and Mental Health Services to Minors in MN).

- Planned Parenthood Federation of America
  - **Information on different State laws. - www.plannedparenthood.org/pp2/portal/files/portal/medicalinfo/abortion/fact-parental-consent.xml**
  - **Information on the different types of minors consent provisions - www.plannedparenthood.org/pp2/portal/files/portal/medicalinfo/abortion/fact-teenagers-abortion-intrusion.xml**

Students with Special Needs

- **Council for Exceptional Children - www.cec.sped.org**
  Journals, newsletters, research, and professional development opportunities for teachers who work with students with disabilities. Search "sex education" in the website's search engine for resources specific to teaching sex education to students with disabilities.

- **ERIC Clearinghouse on Disabilities and Gifted Children - www.ericec.org/faq/sex-ed.html**
  Information regarding sex education and students with disabilities.

Gay, Lesbian, Bisexual, Transgender and Queer Youth

- **Ambiente Joven - www.ambientejoven.org**
  All in Spanish, this website is created by and for Latino GLBTQ youth.

- **OutFront Minnesota - www.outfront.org**
  Minnesota's leading GLBT organization provides programs and services to GLBT and allied communities.

- **Parents, Families, and Friends of Lesbians and Gays (PFLAG) - www.pflag.org**
  PFLAG provides support, education, and advocacy for GLBT persons, as well as their family, friends, and the community.

- **Youth Resource - www.youthresource.com/**
  Created by and for gay, lesbian, bisexual, transgender, and questioning (GLBTQ) youth.

Anatomy

- **Teenwire – http://www.teenwire.com/interactive/diagrams/do-20030930-diag01.php**
  Interactive diagrams of both the female and male internal and external reproductive anatomy

- **Merck Website – http://www.merck.com/mmhe/sec22/ch257/ch257c.html**
  A detailed description of pregnancy stages of development.

- **Advocates for Youth, Reproduction 101 – http://www.advocatesforyouth.org/lessonplans/repro101.htm**
  An anatomy and reproduction lesson, with downloadable print-outs of the male and female anatomy.

Sexual Violence Resources

- **Choose Respect - http://www.chooserespect.org/scripts/**
  An education campaign by the Centers for Disease Control and Prevention, geared to middle school youth to promote healthy relationships and to prevent dating and sexual violence. Many downloadable materials available for educators.

- **Minnesota Coalition Against Sexual Assault (MNCASA) - http://www.mncasa.org/**
  Information about sexual violence and where women and teens living in Minnesota who have been sexually assaulted can seek help are available on this website.

- **Sexual Violence Center (SVC) - www.sexualviolencecenter.org**
  SVC offers age-appropriate presentation on healthy relationships as well as a telephone hotline, counseling and support groups for people who have been sexually assaulted.